CALIFORNIA MEDICAL PROTOCOL FOR EXAMINATION OF SEXUAL ASSAULT AND CHILD SEXUAL ABUSE VICTIMS

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PREFACE

The California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims contains recommended methods for meeting the minimum legal standards established by Penal Code Section 13823.11 for performing evidential examinations. See **Appendix A** for a copy of this code section.

Protocol

The protocol provides the following information:

- standard medical forensic report forms for documentation of findings;
- step-by step procedures for conducting examinations opposite each page of the standard forms;
- expanded information and rationale for the collection and preservation of evidence;
- up-to-date information on sexually transmitted disease and pregnancy prophylaxis;
- helpful information on the dynamics of Rape Trauma Syndrome and the psychological impact of sexual abuse on children;
- approaches to patient care; and,
- relevant information on patient consent, legal issues, financial compensation for examinations, and crime victim compensation.

Required Standard State Forms

OCJP 923	Forensic Medical Report: Acute (< 72 hours) Adult/Adolescent Sexual Assault Examination
OCJP 925	Forensic Medical Report: Nonacute (>72 hours) Child/Adolescent Sexual Abuse Examination
OCJP 930	Forensic Medical Report: Acute (< 72 hours) Child/Adolescent Sexual Abuse Examination

Recommended Standard State Form

OCJP 950	Forensic Medical Report: Sexual Assault Suspect Examination

Key terms for Sexual Assault or Sexual Abuse Examinations

These terms are used to describe time frames. They are not intended to suggest that, after 72 hours, a complete examination should not be done. It is not uncommon to detect physical findings after 72 hours. See Chapter X for a discussion of time frames and the impact of DNA typing and analysis on sexual assault examinations.

Acute	Less than 72 hours have passed since the incident (<72 hours)
Nonacute	More than 72 hours have passed since the incident (>72 hours)

Examine patients without delay

A recommended standard of practice for acute sexual assault or sexual abuse examinations is immediately upon the patient's arrival at the hospital, or within one hour.

Suggested Use of the Standard State Forms: Follow local policy.

OCJP 923	• History of **acute sexual assault** (<72 hours) • Examination of adults (age 18 and over) and adolescents (ages 12-17)
OCJP 925	• History of **nonacute sexual abuse** (>72 hours) • Examination of children and adolescents under 18
OCJP 930	• History of **acute sexual assault or abuse** (<72 hours) • Examination of children under age 12
OCJP 930	• History of **chronic sexual abuse (incest) and recent incident** (<72 hours) • Examination of children and adolescents under age 18
OCJP 950	• Examination of person(s) suspected of sexual assault or child sexual abuse

California Medical Training Center (CMTC)

The California Medical Training Center has been established by state law to provide training for physicians and nurses on how to perform evidential examinations for:

- sexual assault and child sexual abuse;
- domestic violence;
- child physical abuse and neglect; and,
- elder and dependent adult abuse.

Training is also provided to criminal justice and investigative social services personnel on the interpretation of medical findings for use in case investigations, prosecution, and for others involved in the evaluation of forensic evidence. See **Appendix B** for information on how to contact the CMTC.

Considerations in Writing the California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims

Both males and females are victims of sexual assault and sexual abuse. In writing the protocol, gender neutrality was taken into consideration as much as possible. In sections where the use of pronouns was needed, it was agreed to use female pronouns since most victims of sexual assault and sexual abuse are female.

TABLE OF CONTENTS

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Drawings

OCJP 925, OCJP 930, Appendix N and O John McCann, M.D. Medical Director, CAARE Diagnostic and Treatment Center Department of Pediatrics, UC Davis Medical Center Sacramento, CA	OCJP 923 and OCJP 950 David Lobenberg Lobenberg Graphics Sacramento, CA	OCJP 923 and OCJP 950 John Fitzgerald Fitzgerald and Company Sacramento, CA

INTRODUCTION

A. STATUTORY REQUIREMENTS

1. Governor's Office of Criminal Justice Planning

Penal Code Section 13823.5 directs the Governor's Office of Criminal Justice Planning (OCJP) to establish a protocol for the examination and treatment of sexual assault victims, including child molestation, and the collection and preservation of evidence. The statute requires the protocol to contain recommended methods for meeting the minimum standards for evidential examinations specified in Penal Code Section 13823.11. OCJP also has the statutory authority, in cooperation with the Department of Health Services and the Department of Justice, to develop a standard form(s) for recording findings from evidential examinations. A copy of the penal code section is provided in **Appendix A**.

2. Responsibilities of counties

Penal Code Section 13823.9 directs each county to designate at least one general acute care hospital to perform examinations for sexual assault and child sexual abuse victims. The statute also requires each county with a population of 100,000 or more to arrange to have professional personnel, trained in the examination of sexual assault and child sexual abuse victims, present or on call in the county hospital or contracting hospitals providing emergency medical services. In counties with populations of 1,000,000 or more, trained professional personnel must be present or on call for at least one general acute care hospital per 1,000,000 persons in the county.

3. Legal standards for hospitals performing evidential examinations

Health and Safety Code Section 1281 and Penal Code Section 13823.9 require all public and general acute care hospitals to comply with the standards set forth in Penal Code Section 13823.11 for performance of sexual assault and child sexual abuse evidential examinations. If a hospital cannot adhere to the statutory requirements, a protocol must be adopted for immediate referral of sexual assault and child sexual abuse victims to a local hospital that is able to conduct the evidential examination according to the standards established by law. If a referral protocol is adopted, the hospital must notify local law enforcement agencies, the district attorney, and the local victim assistance agencies.

4. Use of required form(s) by health care professionals

Penal Code Section 13823.5 requires every physician or health care professional who conducts an examination for evidence of sexual assault or child sexual abuse to use the standard form(s) adopted by the Office of Criminal Justice Planning, in cooperation with the Department of Justice and State Department of Health Services. The forms are to be used for the recording of medical and physical evidence; and health care professionals are to make such observations and perform such tests as may be required for the recording of the data required

by the form. The forms are subject to the same principles of confidentiality applicable to other medical records. See **Appendix C** for information on how to order forms.

5. California Medical Training Center

Penal Code Section 13823.93 establishes training centers in California to train healthcare professionals on how to perform sexual assault, domestic violence, child abuse and neglect, and elder/dependent adult abuse evidential examinations. Training includes information on examination procedures, interpretation of findings, interviewing, dynamics of victimization, and coordination with criminal justice, juvenile justice, and social service investigative agencies. Training on the interpretation of findings for case investigation is provided for law enforcement and social services investigative personnel. A copy of this penal code section and information on how to access the training centers is provided in **Appendix B**.

B. LOCAL AGREEMENTS

1. Designate primary examination sites

Local agreements between hospitals and law enforcement agencies designating primary examination sites must be developed to ensure prompt evidential examinations and treatment for victims. Alternate sites should be designated in counties with large populations and geographical areas.

2. Negotiate fee agreements for evidential examinations

Reimbursement of hospitals and health care providers for evidential examinations is the responsibility of law enforcement agencies. Refer to Chapter III, Financial Responsibility for Examination, Treatment, and Testing. Development of local fee agreements that are negotiated periodically is recommended.

3. Develop referral protocols

The statutory provision requiring all general acute care hospitals to comply with the minimum standards or adopt a referral protocol is intended to ensure timely and quality care for patients. Front-line personnel in hospitals and potential referring agencies must be informed about the referral protocols.

C. STATUTORY STANDARDS AND THE PROTOCOL

The protocol, including forms and instructions, contains recommended methods for meeting the statutory standards. Flexibility is needed, however, to accomplish these tasks as circumstances may vary and new methods may evolve with advancing technology and research. The important considerations are whether alternate methods support quality medical examinations, evidence collection and preservation procedures, law enforcement investigation, and case prosecution; and whether these methods are consistent with local law enforcement and crime laboratory policies.

CHAPTER I

NOTIFICATION OF INJURIES TO AUTHORITIES

A. SEXUAL ASSAULT

1. Report crime-related injuries to the local law enforcement agency

Hospitals and health practitioners are required to report to the local law enforcement agency all cases in which medical care is sought where injuries have been inflicted upon any person in violation of any state penal law. The report must be made immediately by telephone and in writing within two working days of receiving the information. It must state the name of the injured person, if known, the current whereabouts, the character and extent of injuries, and the identity of the alleged perpetrator, if known (Penal Code Section 11160).

2. Criminal penalties for failure to report injuries to authorities

The failure of a hospital or health practitioner to report cases where injuries have been inflicted in violation of a state penal law is punishable by a fine not to exceed $1000, by imprisonment in the county jail for a period not to exceed six months, or both (Penal Code Section 11162).

3. A Partial List of California Penal Code Sections on Sexual Assault

Penal code sections on sexual assault include: 261 (Rape); 264.1 (Rape in Concert); 288a (Oral Copulation); 286 (Sodomy); 289 (Penetration of a Genital or Anal Opening by a Foreign Object); 262 (Spousal Rape); 220 (Assault with Intent to Rape); 243.4 (Sexual Battery); 261.5 (Unlawful Sexual Intercourse with a Female Under Age 18); 266c (Unlawful Sexual Intercourse, Oral Copulation or Sodomy and Consent is Procured by Fear or Fraudulent Representation with Intent to Create Fear); and, 664 (Designation for Attempts to Commit a Crime).

4. Definition of Sexual Penetration

Penal Code Section 263 states that "any sexual penetration, however slight, is sufficient to complete the crime." The courts have held that "to constitute 'rape,' it is not necessary that there be complete penetration, in view of the statutory provision that any sexual penetration, however slight, is sufficient to complete the crime of rape." People vs. George (App. 1949) 91 Cal. App. 2d537, 205 P. 2d464. Another case states "penetration of lips of female's vagina is sufficient to constitute rape and rupture of the hymen is not necessary." People vs. Esposti (App. 1 Dist. 1947) 82 Cal. App. 2d76, 185 P. 2d866.

B. CHILD ABUSE

1. Report known or suspected child abuse to child protective agencies

Health practitioners are required to report known or suspected child abuse immediately by telephone and send a written report within 36 hours to a child protective agency.

$ A health practitioner means a physician, surgeon, psychiatrist, psychologist,

dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

- $ A child protective agency means a law enforcement agency, the county department of social services, or the county probation department.
- $ The obligation of health practitioners to make a report to a child protective agency arises when they, in their professional capacity, have knowledge of or observe a child who they know or reasonably suspect has been the victim of child abuse.
- $ No supervisor or administrator may impede or inhibit the reporting duties and no person making such a report shall be subject to any sanction for making the report (Penal Code Sections 11165-11168).

2. Criminal penalties for failure to report child abuse

The failure of medical practitioners and other mandated persons to report child abuse is punishable by a fine not to exceed $1,000, by imprisonment in the county jail for a period not to exceed six months, or both (Penal Code Section 11162).

3. A Partial List of California Penal Code Sections on Child Sexual Abuse

Penal Code sections on sexual abuse include: Sections 261 (Rape); 261.5(d) (Statutory Rape); 264.1 (Rape in Concert); 285 (Incest); 286 (Sodomy); subdivisions (a) and (b) of 288 (Lewd or Lascivious Acts Upon a Child Under 14 Years of Age); 288a (Oral Copulation); 289 (Penetration of a Genital or Anal Opening by a Foreign Object); 647.6 (Child Molestation); and, 311.4 (Child Pornography).

4. Definition of Sexual Abuse

Penal Code Section 11165.1 defines child sexual abuse to mean sexual assault or sexual exploitation as the following:

- $ Any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen.
- $ Any sexual contact between the genitals and anal opening of one person and the mouth or tongue of another person.
- $ Any intrusion of one person into the genitals or anal opening of another person, including the use of any object for this purpose, except that it does not include acts performed for a medical purpose.
- $ The intentional touching of the genitals or intimate parts (including the breasts, genital area, groin, inner thighs, and buttocks) or the clothing covering them, of the child, or of the perpetrator by a child, for purposes of sexual arousal or gratification, except that it does not include acts which may reasonably be construed to be normal caretaker responsibilities, interactions with, or demonstrations of affection for, the child; or acts performed for a valid medical purpose.

$ The intentional masturbation of the perpetrator's genitals in the presence of a child.

$ Sexual exploitation referring to child prostitution or pornography

5. Notification procedures to comply with Penal Code Sections 11165-11168

- Telephone reports to child protective agencies must include the following information:
  - $ Name of the person making the report;
  - $ Name of the child;
  - $ Present location of the child;
  - $ Nature and extent of the injury; and
  - $ Other information requested by the child protective agency.

$ To comply with Penal Code Section 11166 which requires the submission of a written report to a child protective agency within 36 hours, submit Suspected Child Abuse Report (DOJ SS 8572) to a child protective agency. See **Appendix D** for a copy of this form.

6. Immunity from civil or criminal liability for complying with the child abuse reporting law

- Health practitioners and others required to report known or suspected child abuse cannot be held civilly or criminally liable for any report required or authorized by the child abuse reporting law. (Penal Code Section 11172)

$ Physicians and hospitals may be held liable for injuries sustained by a child for failure to diagnose and report child abuse to authorities resulting in the child being returned to the parents and receiving further injuries by them (Landeros v. Flood, (1926) 131 CAL. RPTER 69, 551 P.2d 389, 17 C.3d 399, 97 A.L.R. 3d 324).

7. Confidentiality/child abuse reports

Written reports required by the child abuse reporting law are confidential and can only be released to child protective agencies; multidisciplinary personnel teams (defined in subdivision (d) of Section 18951 of the Welfare and Institutions Code); persons or agencies responsible for the licensing of facilities which care for children; hospital SCAN (Suspected Child Abuse and Neglect) teams; and, coroners and medical examiners. Any violation of confidentiality is punishable by up to six months in jail, by a fine of $500, or both (Penal Code Section 11167.5).

CHAPTER II

PATIENT CONSENT FOR EXAMINATION, TREATMENT, AND EVIDENCE COLLECTION

A. ADULTS

To protect the rights and interests of both the adult patient and the hospital, appropriate signed consents must be obtained before examination, treatment, and evidence collection begins.

1. Consent to medical examination and treatment only

- General consent for routine diagnostic and medical procedures, informed consent for more complex procedures, and consent for emergency treatment must be obtained in accordance with hospital policy.

$ At the onset of the consent interview, the patient must be informed that examination and treatment for injuries inflicted in violation of any state penal law obligates the hospital and health practitioner to make a telephone and written report to the local law enforcement agency.

2. Consent to medical examination, collection and preservation of evidence

- If the patient consents to the medical examination for collection of evidence, the Patient Consent section (for patients age 12 and older) on the required forms must be signed. This indicates the patient understands that evidence will be collected, preserved, and released to law enforcement authorities.

$ Patients must be given the following information:

$ Patients have the right to refuse an examination for the purpose of collecting evidence.

$ Consent for evidence collection, once given, can be withdrawn at any time for all or part of the examination. Once evidence has been collected, however, and given to the law enforcement agency or to the crime lab, it is no longer under the patient's control.

$ Evidence includes photographs of injuries and these photographs may include the genital area.

$ Patients have the right to refuse the collection of reference specimens, such as pubic and head hair; blood and/or saliva for typing; and blood and/or urine for toxicology analysis.

$ If the patient does not permit collection of reference specimen(s) at the time of the examination or at a later date, the crime laboratory cannot conduct a comparative analysis of the evidence in question.

$ Physical evidence deteriorates and will be unobtainable if not collected and preserved promptly.

$ The cost of an evidential examination is the responsibility of the local law enforcement agency only if the patient consents to the collection of

evidence (Penal Code Section 13823.95). If the patient does not consent to evidence collection, the patient is responsible for the costs of the medical examination. If the patient has agreed to collection of evidence, medical treatment facilities are prohibited by law from directly or indirectly charging the sexual assault victim for the cost of the evidential examination. The term "indirectly charging" means third-party payers such as health insurance companies or Medi-Cal.

$ Data, including photographs, without patient identification may be collected from the form related to public health and criminal justice research purposes. A computerized software program is being developed for this purpose. Contact the California Medical Training Center for further information. See **Appendix B.**

3. Sexual Assault Suspect Evidential Examinations

Patient consent is not required for these examinations if the suspect is in custody. See Section D: Persons Arrested for Suspected Sexual Assault in this chapter and Chapter XX Sexual Assault Suspect Evidential Examination.

4. Collection of evidence without immediate release to the law enforcement agency

Patients uncertain about whether to consent to an evidential examination may not be able to make this decision immediately. If the hospital has a policy and the capability of storing evidence frozen in a secure area, patients may be encouraged with this information to consent to have evidence collected at the time and released later - with their permission - to law enforcement authorities.

It is important, however, to maintain a complete chain of custody. Acceptance of these delayed release procedures may vary between jurisdictions. Contact local law enforcement agencies, the district attorney's office, and the crime laboratory for consultation.

B. MINORS

1. Consent to treatment

- Minors, 12 years of age or older, may give consent to the provision of medical care related to the diagnosis or treatment of a sexual assault and the collection of evidence (Family Code Sections 6927 and 6928).

$ Minors, 12 years of age or older, may give consent to the provision of medical care related to the prevention or treatment of pregnancy (Family Code Section 6925).

$ Minors, 12 years of age or older, may give consent to the provision of medical care related to the diagnosis or treatment of sexually transmitted diseases (Family Code Section 6926).

$ Consent given by a minor is not subject to disaffirmance because of minority (Family Code Section 6921).

$ Family Code Section 6500 defines a minor as an individual who is under 18

years of age.

2. Notification of parents

Professional personnel rendering medical treatment for sexual assault of a minor are required to attempt to contact the minor's parent(s) or legal guardian of the minor, and to note in the minor's treatment record the date and time the attempted contact was made and whether the attempt was successful or unsuccessful. This provision is not applicable when the professional person reasonably believes the parent(s) or guardian of the minor committed the sexual assault on the minor (Family Code Section 6928).

C. CHILDREN/MINORS

1. Suspected child abuse: non-consenting parents

Parental consent is not required to examine, treat or collect evidence for suspected child abuse. In the absence of parental consent or in case of parental refusal, children must be taken into protective custody by a child protective agency in order to perform the examination. A representative of the child protective agency must sign the OCJP 925 or the OCJP 930 as the temporary guardian of the child to authorize the procedures.

2. Photographs of injuries

Skeletal x-rays or photographs may be taken of known or suspected child abuse victims and included with reports to child protective agencies without parental consent (Penal Code Sections 11171.5).

3. Child sexual abuse: parents requesting examinations without involvement by law enforcement or child protective services

- $ Once a health practitioner has a "reasonable suspicion", the legal obligation to report arises.
- $ Payment for an evidential examination at public expense can only be authorized by a child protective agency (law enforcement agency, county department of social services, or county probation department).
- $ Child sexual abuse cases have complex intrafamily dynamics which require evaluation by experienced professionals. Health practitioners should not consider handling the matter privately.

4. Adolescent voluntary sexual activity/parental demand for examination

Cases in which parents request an evidential examination to determine whether their child has been sexually active and allege violation of Penal Code Section 261.5 (Unlawful Sexual Intercourse with a Person Under Age 18) require sensitive handling. Many medical facilities establish the policy that if minors, 12 years of age and older, have the right to give consent for the diagnosis and treatment of sexual assault (Family Code Sections 6927 and 6928); they have the right to refuse consent. Consult with local law enforcement agencies and follow local policies.

D. PERSONS ARRESTED FOR SUSPECTED SEXUAL ASSAULT

Hospitals are not required by law to perform suspect examinations and no obligation is implied by the inclusion of this material in the protocol. Hospitals are encouraged to assist with law enforcement investigations, if called upon, and local agreements are recommended.

1. **Patient consent is not required for these evidential examinations if the suspect is in custody.**

   See Chapter XX Sexual Assault Suspect Evidential Examination.

2. **Develop local protocols for involuntary suspect examinations**

   Persons who have been placed under arrest do not have the right to refuse an examination for the collection of physical evidence. Case law defining "search incident to arrest" permits the search of an arrested person for evidence relevant to the crime for which they are suspected. If the suspect is in custody and is unwilling to consent to the examination, evidence such as dried secretions, foreign materials, and blood samples for alcohol analysis can be collected from the person without a search warrant and without the person's consent if the law enforcement officer believes the delay necessary to obtain a court order would result in the possible loss or destruction of evidence. The use of force or restraints to collect evidence from a non-consenting suspect is an issue that requires consultation with local law enforcement, the district attorney's office, and hospital counsel. Development of a local protocol is recommended.

3. **Reimbursement for examinations**

   Examinations of persons suspected of sexual assault must be authorized by a law enforcement agency to obtain reimbursement.

4. **Recommended Form**

   OCJP 950: Forensic Medical Report, Sexual Assault Suspect Examination has been developed to facilitate standardized evidential examination of suspects.

CHAPTER III

FINANCIAL RESPONSIBILITY FOR EXAMINATION, TREATMENT, AND TESTING

A. HOSPITAL REIMBURSEMENT FOR EXAMINATIONS

1. Costs Incurred by Emergency Medical Facilities for Forensic Medical Examinations of Sexual Assault Victims (Penal Code Section 13823.95)

No costs incurred by a qualified health care professional, hospital, or other emergency medical facility for the examination of a victim of a sexual assault, as described in the protocol developed pursuant to Section 13823.5, when the examination is performed, pursuant to Sections 13823.5 and 13823.7, for the purposes of gathering evidence for possible prosecution, shall be charged directly or indirectly to the victim of the assault. These costs shall be treated as local costs and charged to the local governmental agency in whose jurisdiction the alleged offense was committed.

Bills for these costs shall be submitted to the law enforcement agency in the jurisdiction in which the alleged offense was committed and which requests the examination.

The law enforcement agency in the jurisdiction in which the alleged offense was committed which requests the examination has the option of determining whether or not the examination will be performed in the office of a physician or surgeon.

2. Medical examination without evidence collection

If the patient does not consent to evidence collection, the cost of the examination is the responsibility of the patient.

B. AUTHORIZATION FOR FORENSIC MEDICAL EXAMINATIONS

Law enforcement authorizations for forensic medical examinations for sexual assault or child sexual abuse are handled in several ways:

1. OCJP 923, OCJP 925, OCJP 930, and OCJP 950 are signed by a law enforcement officer

Care must be taken, however, to ensure that a completed forensic medical report is not sent through the medical facility's billing system as a means of generating a charge to a law enforcement agency.

2. A separate authorization form is signed by a law enforcement officer

The advantage to this procedure is that a separate form is used to generate a charge for the billing system, and can be used to document that the examination was authorized by a law enforcement officer.

3. **A telephone authorization procedure is established between hospitals and law enforcement agencies**

   This policy and procedure is useful in busy urban counties where law enforcement might not be able to respond quickly to the hospital, or in rural counties where there are long distances to travel. This allows the medical team to begin the forensic medical examination as soon as possible.

4. **Courtesy authorization between law enforcement agencies**

   This policy is helpful in situations where a victim goes to a nearby hospital outside the jurisdiction of the law enforcement agency in which the crime occurred. One law enforcement agency signs or authorizes the forensic examination on behalf of the other.

5. **Contracts and Memorandums of Understanding (MOUs)**

   Medical facilities with contracts and memorandums of understanding may not require separate patient authorizations. Follow local policy.

C. MEDICAL TREATMENT

Medical expenses for treatment of injuries resulting from a sexual assault are the responsibility of the patient. Victims of sexual assault can be reimbursed for out-of-pocket medical expenses by submitting an Application for Crime Victim Compensation to the State Board of Control Victims of Crime Program. See Chapter IV Crime Victim Compensation and Victim Assistance Programs.

D. TESTING FOR SEXUALLY TRANSMITTED DISEASE (STD) AND PREGNANCY

County hospitals, or the public health department in counties without county hospitals, must provide victims of rape or sexual assault with testing for venereal disease and pregnancy without charge (Health and Safety Code Section 1491). STD and pregnancy testing, however, are not required by this protocol for adults and sexually active adolescents. STD testing is recommended for children and non-sexually active adolescents under the circumstances described in Chapter XXII. Pregnancy testing for pre-adolescents and adolescents is discussed in Chapter XXI.

CHAPTER IV

CRIME VICTIM COMPENSATION/VICTIM ASSISTANCE PROGRAMS

A. CRIME VICTIM COMPENSATION

1. Eligibility

- $ A California resident or out-of-state resident injured in California who suffers physical injury and/or threat of physical injury, or death. (Victims of sexual assault and child sexual abuse are presumed to have suffered physical injury.)
- $ Family members or persons having close personal relationships with the victim and who are California residents.

2. Losses that are covered

- $ Most medical bills
- $ Physical and psychological therapy expenses
- $ Funeral/burial costs
- $ Wage loss
- $ Loss of financial support
- $ Job retraining expenses

3. Reimbursable expenses

Victims of violent crime must be informed that they are eligible to receive a limit of $46,000 for out-of-pocket expenses for treatment of injuries resulting from the crime, lost wages, and job retraining and rehabilitation. Expenses for psychological counseling are also reimbursable.

4. Examples of eligible victims

- $ Murder victims
- $ Rape victims
- $ Battered women
- $ Child physical and sexual abuse victims
- $ Assault victims
- $ Robbery victims
- $ Domestic Violence victims
- $ Hit and Run victims
- $ Victims of Acts of Terrorism
- $ Victims of Drivers Under the Influence

5. Requirements

- $ The crime must be reported to law enforcement or child or adult protective services.

- $ The victim must cooperate with law enforcement in the investigation and prosecution of any known suspect(s). If the victim is a child who has been confirmed as abused, the child may qualify with or without the child's legal guardian's cooperation with the authorities, or the identification or prosecution of any known suspects.
- $ The victim must not have knowingly and willingly participated in the commission of the crime or engaged in conduct that causes or leads to the crime.
- $ Victims (18 years or older at time of the crime) must file an application with the State Victims of Crime Program within one year from the date of the crime. Victims (under 18 years of age at the time of crime) must file the application before their 19th birthday.
- $ Eligibility for program benefits may be limited if the victim/claimant was convicted of a felony committed on or after January 1, 1989, and has not been discharged from probation, parole, or released from a correctional institution at the time of the incident (Government Code Section 13960.2).

6. Hospitals' responsibilities

- $ **Display posters in the emergency room**
  Licensed hospitals in the state of California must prominently display posters in the emergency room notifying crime victims of the availability of victim compensation and the existence and location of local county victim/witness assistance centers (Government Code Section 13968).
- $ **Provision of crime victim compensation claim forms**
  County hospitals must provide Application for Crime Victim Compensation forms to sexual assault victims (Health and Safety Code Section 1492).

7. Assistance in filing claims

Additional information on crime victim compensation may be obtained by contacting local county victim/witness assistance centers or the State Victim's of Crime Program. Local victim/witness programs provide assistance to victims in the preparation and submission of these claims to the State Victims of Crime Program.

Victims may also be assisted by a private attorney in filing claims. California Government Code Section 139650(d) provides that the Board shall pay private attorney fees of 10 percent of the approved award up to a maximum of $500, and these fees are not deducted from the applicant's award.

8. Limitations

- $ The Victims of Crime Program is the "payer of last resort." Other sources of reimbursement such as health or disability insurance must be used first.
- $ Consult local county victim/witness assistance centers for further information.

B. CRIME VICTIM ASSISTANCE CENTERS

Rape crisis centers, victim/witness assistance centers, domestic violence shelters,

child sexual abuse treatment programs, and special crime victim counseling centers exist in California to provide counseling and other forms of assistance to crime victims. For further information, call the State Victims of Crime Program at 1-800-777-9229 or the Crime Victim' s Resource Center at 1-800-VICTIMS. Refer to **Appendix E** and **F** for lists of rape crisis centers and victim/witness assistance centers.

CHAPTER V

GENERAL PATIENT CARE

A. ACUTE INJURY AND TRAUMA CARE

1. **First respond to acute injury and trauma care needs. After initial evaluation, management, and stabilization of acute problems, perform the forensic medical examination.**

2. **Be supportive and empathetic in your approach**. **Sensitive medical care can:**
   - $ Reduce acute psychological trauma and its aftereffects;
   - $ Support existing and emerging coping skills; and
   - $ Set the tone for resumption of normal functioning.

B. EXAMINER'S APPROACH TO PATIENTS

1. Upon arrival

- $ Provide privacy for patients promptly upon arrival and during all aspects of care.
- $ Contact the local rape crisis center for a victim advocate to provide immediate and follow-up support for the patient. See Chapter VI.C, The Role of the Rape Crisis Center Advocate.
- $ Conduct the examination as soon as possible to reduce fear and trauma and to prevent loss of evidence.
- $ Provide an explanation to alleviate stress caused by waiting if delays occur.

2. Prior to the examination

- $ Introduce yourself to patients and apprise them of your role.
- $ Ask patients how they want to be addressed and refer to them by that name.
- $ Establish a positive examiner-patient relationship. **For male examiners**, consider having a female nurse or nursing assistant or female rape crisis center advocate in the examination room for patient reassurance.
- $ Privately inquire of patients if the presence of a friend, relative, victims advocate, or social worker is desired or not. Let them know in advance that highly personal, sensitive information will be discussed.
- $ **Keep in mind that patients may not fully disclose sexual acts if another person is present (especially a spouse or family member).**

  Adolescents, in particular, may want to privately describe the sexual acts and discuss past history without having a parent present.

  Children should be interviewed alone, away from family members, as they are very sensitive to any parental reaction to the disclosure of details

regarding the sexual abuse. The possibility also exists that the non-offending parent or caretaker in intrafamilial cases may have colluded with the perpetrator, been in denial, or been non-responsive to the child's previous attempts to disclose information.

- $ Approach and respond to patients in a supportive, nonjudgmental manner.
- $ Provide supportive interventions that assist patients to regain feelings of safety, control, trust, and positive self-regard.
- $ Avoid slang terms and inappropriate references, e.g. "there's a rape victim in that room."

3. During the examination

- $ Explain what is being done and why, as well as the reasons for questions asked.
- $ Inform patients of findings regarding their physical condition as the examination is conducted.
- $ Ask only what is necessary to collect evidence and to complete a thorough examination.
- $ Build rapport and lead gradually to sensitive questions.
- $ Use terminology clearly understood by patients in referring to sexual acts and parts of the body.
- $ Avoid the appearance of prurient interest or questions about a patient's reasons or motivation such as "Why did you do that?"
- $ Accept each patient's response as an individual adaptation to a personal crisis. Reactions vary from outward calm to strong emotional expression.
- $ Encourage patients to express feelings, concerns, and needs related to the assault.
- $ Explicitly acknowledge the sexual assault and its traumatic nature.
- $ Be patient and allow the patient to set the pace. Never pressure or interrogate the patient.
- $ Involve patients of appropriate age in decision-making regarding treatment, follow-up care, and notification of family members or others.
- $ Provide patients with age-appropriate information regarding physical and psychological sequelae to sexual assault.

4. After the examination

- $ Provide a change of clothing, if needed.
- $ Refer to Chapter XXIII Follow-Up Patient Care.
- $ Refer the patient to the local rape crisis center or child sexual abuse treatment program.

5. Interviewing Adults, Adolescents, and Children

- Refer to Chapter VII Specialized Interview Teams for Children
- Refer to Chapter XIX Interviewing Adults, Adolescents, and Children

C. ENSURING QUALITY OF FORENSIC MEDICAL EXAMINATIONS

The establishment of a specialized forensic medical examination team is recommended. See Chapter VI Specialized Forensic Medical Examination Teams. Hospitals that have not formed these teams must ensure that a health care professional is assigned to organize the system and quality of service delivery for sexual assault and child sexual abuse victims.

Suggested responsibilities of the team member on-call or on duty or the patient care coordinator are:

1. **During the examination**
   - $ Ensure that the forensic medical examination is conducted promptly.
   - $ Ensure that the protocol is followed according to the standards set forth in this document, the forms and instructions, and that local jurisdictional issues are properly addressed.
   - $ Ensure that the reporting requirements to law enforcement and/or child protective agencies are followed when injuries have been inflicted upon adults or children in violation of state penal laws.
   - $ Explain to patients the steps of the protocol and the reasons for the procedures.
   - $ Ensure that patients receive psychological support during the forensic medical examination.
   - $ Notify and serve as liaison with families and friends, and provide supportive intervention to reduce their stress.
2. **Following the examination**
   - $ Arrange follow-up care for treatment of injuries, sexually transmitted disease, pregnancy, forensic follow-up medical examinations, and photographs, etc.
   - $ Provide information about crime victim compensation for reimbursement of out-of-pocket medical expenses, lost wages, psychological counseling, and job retraining and rehabilitation services.
   - $ Provide referrals to local rape crisis centers, child sexual abuse treatment programs, local county victim/witness assistance centers, available psychological counseling resources, and other needed services.
   - $ Arrange transportation for patients when needed.
   - $ Monitor civil and criminal court subpoenas to ensure patient privacy rights are not violated.

CHAPTER VI

SPECIALIZED FORENSIC MEDICAL EXAMINATION TEAMS

A. COORDINATED APPROACH TO PATIENT CARE

Many communities are developing specially trained examiner programs using physicians, mid-level practitioners (nurse practitioners and physician assistants) or nurses. Each model has a physician medical director.

There are various acronyms for these teams: SAFE (Sexual Assault Forensic Examiners), SANE (Sexual Assault Nurse Examiners), SART (Sexual Assault Response Team), CARE (Child Abuse Response Examiners), and CAST (Child Abuse Services Team). The SART acronym is also used as a broader concept to describe a coordinated response between patrol officers, detectives, rape crisis center advocates, crime laboratories, the district attorney's office, and the forensic medical examination team.

Some teams are hospital-based and some are freestanding. They are dedicated to timely, comprehensive attention to the medical and emotional needs of the patient and to the forensic needs of the criminal and juvenile justice system. To function optimally, regular meetings between representatives of the various disciplines are recommended.

B. KEY FEATURES OF SPECIALIZED TEAMS

- $ Coordinated team notification and assembly;
- $ Prompt forensic medical examinations for acute cases;
- $ Highly trained medical examiners;
- $ Defined areas of expertise in either sexual assault, child sexual abuse, or both;
- $ Pre-authorization for reimbursement based upon negotiated contracts;
- $ Dedicated exam space and equipment;
- $ Immediate victim support and advocacy;
- $ Coordinated medical/law enforcement interviews;
- $ Specialized training for all team members;
- $ Peer review;
- $ Continuous quality improvement;
- $ Collaboration and cooperation with community resources; and
- $ Standards of practice.

C. THE ROLE OF THE RAPE CRISIS CENTER ADVOCATE

1. Origin of the Anti-Rape Movement

The women’s movement emerged out of the civil rights movement in the late 1960's and spawned two major social movements on behalf of women in the

1970's – the anti-rape movement and the social movement on behalf of battered women. The anti-rape movement developed out of “Speak Outs” in which women gathered and recounted stories of victimization by perpetrators and by individuals and systems responsible for helping them. The first “Speak Out” was held in New York City in 1971. BAWAR (Bay Area Women Against Rape) was the first rape crisis center established in the United States in Oakland, California in 1973. This center still exists today.

2. Standard Services Offered by Rape Crisis Centers

- 24-hour crisis intervention;
- follow-up counseling by telephone and in-person;
- individual and group counseling sessions;
- advocacy and accompaniment services during medical examinations, law enforcement investigations, and court proceedings;
- information and referral services for victims and the general public;
- community and school education;
- self defense classes, sexual assault prevention, and education programs; and
- training for other agency professionals who interact with sexual assault victims.

3. Role of the Rape Crisis Center Advocate at the Health Care Facility

The role of the advocate is to provide emotional support to the patient, to explain and clarify procedures, to work with family members in crisis, and to advocate on behalf of the patient to ensure that prompt, considerate care is provided.

D. URBAN AND RURAL TEAM MODELS

Large urban hospitals may specialize and have one team for victims of sexual assault and one team for victims of child sexual abuse. Rural teams often serve all ages - adults, adolescents, and children. Some rural teams in proximity to urban centers may choose to perform the acute child sexual abuse examination and refer the non-acute sexual abuse examinations to specialized centers.

There are at least three types of program models for forensic medical examination teams:

1. Primary Hospital Programs

$ one hospital is designated by the community to perform forensic examinations;

$ the team members are regular shift employees or employed on an on-call basis;

$ the hospital provides examination space and equipment; and

$ the hospital contracts with law enforcement agencies for reimbursement.

2. Multi-Hospital Program

- $ a nurse examiner team contracts with various community hospitals;
- $ the team works on an on-call basis responding to contract hospitals; and
- $ the hospitals provide examination space and equipment.

3. Multi-Disciplinary Co-Location Program

- $ a multi-disciplinary team composed of forensic medical examiners, law enforcement officers and victim advocates are co-located in one facility;
- $ the facility may be non-medical, but arrangements are made to refer trauma cases to a local hospital; and
- $ there is dedicated space and equipment for examinations.

E. TWO CONSUMERS: TWO SETS OF NEEDS

1. Patient Needs

- $ Prompt medical evidential examinations performed by trained examiners;
- $ Crisis intervention and emotional support;
- $ Prophylaxis against sexually transmitted disease;
- $ Assessment of pregnancy risk (Tanner Stage 3 and above); and
- $ Follow-up care for medical and emotional needs.

2. Criminal Justice and Juvenile Justice Systems

- $ Accurate patient history of the assault or abuse**;**
- $ Documentation of physical findings;
- $ Proper collection and handling of evidence for acute evidential exams;
- $ Interpretation of findings; and
- $ Presentation of findings and provision of expert opinion.

F. STANDARD TRAINING CURRICULUM FOR TEAMS

Standard curriculum for adult and child forensic medical examination teams has been developed by the California Medical Training Center. See **Appendix B** for further information.

G. CONTINUOUS QUALITY IMPROVEMENT (CQI)

Formal CQI review is an essential standard of practice for medical forensic examination teams. Some community hospitals have developed CQI for the forensic medical team operations and participate in regular SART CQI with the local crime laboratory, district attorney's office, and law enforcement agencies. SART CQI sometimes includes brief evaluation forms from the crime laboratory regarding the quality of evidence collection, preservation, and handling for the examination team on a per case basis. See **Appendix B** on how to contact the California Medical Training Center for further information.

H. CASE CONSULTATION

There are currently four models for case consultation:

$ POTS (Plain Old Telephone System) and POMS (Plain Old Mail System)

An examiner in one community requests telephone consultation from a more experienced examiner, and/or may send photographs of injuries and findings in advance for discussion.

$ Monthly Case Consultation Meetings

Monthly case consultation meetings involving photo review are held between urban and rural child sexual abuse examiners in Northern and Southern California. The purpose of these regular meetings is to improve quality and consistency in the interpretation of findings. Meetings are rotated between hospital sites to increase access to the meetings.

$ Telemedicine

Telemedicine increases access between examiners for expert opinion and case consultation, and involves the transmission of photographs and/or videotapes of injuries and findings from one site to another for consultation. This technology involves the use of a software program that addresses the issues of confidentiality, records transmission and storage. The system is typically set up in advance between sites to ensure equipment compatibility.

$ See Chapter XIII on Consultation Through Telemedicine and Technology.

CHAPTER VII

SPECIALIZED INTERVIEW TEAMS FOR CHILDREN

A. PURPOSE

Multi-Disciplinary Interview Centers (MDICs), sometimes called Multi-Disciplinary Interview Teams (MDITs), have been developed in many counties to:

- $ reduce multiple, repetitive interviews of sexually abused children;
- $ reduce psychological trauma;
- $ improve the quality and consistency of child interviews;
- $ improve and coordinate decision-making regarding the need for medical evidential examinations;
- $ coordinate the inter-disciplinary response between law enforcement, deputy district attorneys, social workers, and health practitioners; and
- $ improve coordination and case planning between law enforcement and child protective services (CPS).

B. MODEL APPROACHES

Child interviewing has emerged both as an art and a science. Research published in peer review journals exists on the process of disclosure, and how children understand and answer questions. In addition to technical knowledge, interviewers must have the ability to establish rapport with children, engage them in discussion about sensitive matters, and understand that children under stress are likely to "stonewall" (put up verbal and nonverbal barriers) or deny what happened.

In the drive to reduce repetitive interviews and in the context of high caseloads, an imbalance has occurred in some settings. An over-reliance has developed on the "one-stop" comprehensive interview. Decision-making becomes over-focused on whether the child gave a "good MDIT interview" that day. Research is showing that children tend to disclose events over time as they "test the waters" to see what is safe to say and whether or not there is support for them.

In general, the model program approach to child interviewing has the following features:

- $ Developmentally appropriate, forensically defensible questions and methods are used consistent with the age of the child;
- $ Child interview specialists are specially trained using standard curriculum;
- $ An interview protocol designed to address law enforcement investigation and child protection needs is followed;
- $ The interview setting has a warm, child-friendly atmosphere;
- $ Opportunity exists for follow-up interview(s) by the same interviewer;
- $ Interviews are videotaped;

- $ Interviews are observed through a one-way glass by a deputy district attorney from a child abuse prosecution unit, a detective, and a CPS social worker;
- $ Arrangements are in place for child sexual abuse evidential examinations to be performed by specially trained medical examiners;
- $ Crisis intervention can be provided;
- $ Follow-up case management and referrals for mental health counseling are made; and
- $ Accurate information and support on how to access the State Victims of Crime Program for reimbursement of counseling expenses are given.

C. ORGANIZATION AND STAFFING

Staffing varies between centers according to resources. There are two basic models, and several variations of "organizational home" structures:

- $ **Site models with specialized staff.**
  The program is located at a specially designed "child friendly" site. Typical staffing includes a program coordinator and child interview specialist. Children are brought to the site, which has a specially designed interview room with videotape equipment and a one-way glass. Detectives, CPS social workers, and a deputy district attorney convene to observe the interview and make case planning and management decisions.
- $ **Joint Response Model**
  In this model, CPS social workers and law enforcement officers coordinate to conduct joint interviews. The interviews take place at various locations, sometimes at a specified site. Interviews are conducted either by CPS social workers or by law enforcement officers who are trained as interview specialists.
- $ **"Organizational Home" Structures**
  MDICs and MDITs are commonly placed in county district attorneys' offices or child protective services. Sometimes they are operated by non-profit organizations or are sponsored by the local child abuse prevention council.

D. DIFFERENCES BETWEEN MEDICAL INTERVIEWS AND SPECIALIZED FORENSIC INTERVIEWS

It is important to understand the difference between a medical history taken prior to performing an examination and a forensic interview typically performed by a law enforcement officer, investigative social worker, or MDIT (Multi-Disciplinary Interview Team).

1. Purpose of a medical interview conducted by physicians and nurses

- $ to determine the likelihood that a child's signs and symptoms are consistent with sexual abuse;
- $ to establish the type of physical findings that may be present;
- $ to ascertain if a child needs treatment; and
- $ to provide information to law enforcement officers, investigative social

workers, deputy district attorneys, defense attorneys, and judges about the history and whether it is consistent with case findings.

2. **Purpose of a specialized forensic interview**
   - $ to establish the child's ability to accurately relate a history;
   - $ to enhance communication while reducing suggestibility;
   - $ to obtain a detailed description of the events:
     - $ who
     - $ when
     - $ what
     - $ where
     - $ how
     - $ how many times; and,
   - $ to avoid unnecessary multiple interviews of the child.

Contact your county department of health and human services, law enforcement agencies, district attorney's office, or child abuse prevention council to determine whether an MDIT or MDIC exists in your community.

CHAPTER VIII

KNOWLEDGE AND SKILLS NEEDED BY MEDICAL PERSONNEL IN THE PERFORMANCE OF SEXUAL ASSAULT EVIDENTIAL EXAMINATIONS

Standard curriculum has been developed by the California Medical Training Center for training sexual assault forensic examiners. Advanced and specialized courses are under development. The statements listed below are brief summaries of course objectives.

A. KNOWLEDGE

Medical personnel performing evidential examinations must be knowledgeable about:

- $ the broad spectrum of potential evidence and physical findings present in these cases;
- $ the importance of the sexual assault history;
- $ the dynamics and outcomes of victimization related to sexual assault;
- $ preventing loss, degradation, deterioration, and contamination of evidence;
- $ proper evidence collection and preservation procedures;
- $ samples needed for toxicological analysis;
- $ collection of reference samples;
- $ indications for both medical and forensic follow-up;
- $ state laws regarding the performance of sexual assault forensic medical examinations, the state protocol, and the standard forms used to document findings;
- $ the roles of law enforcement and child protective services, rape crisis centers, deputy district attorneys, and crime laboratories;
- $ how to obtain both crisis intervention and longer term mental health counseling;
- $ how to effectively testify as an expert witness; and
- $ how to identify a consultative network for on-going peer review of medical evaluations and interpretation of findings.

B. SKILLS

Medical personnel must be able to:

- $ Perform a medical screening examination to assess the patient's clinical condition and to make appropriate and timely triage, consultation, and referral decisions;
- $ sensitively interview patients to obtain a complete sexual assault history;
- $ utilize patient history to perform a complete forensic medical examination;

- $ explain to the patient what items need to be collected and for what purpose;
- $ identify and describe pertinent female and male genital and anorectal anatomical structures;
- $ use enhancement techniques for detection and documentation of findings, e.g., colposcopy and forensic photography;
- $ collect, label, document, and preserve all types of evidence for analysis by the crime laboratory;
- $ maintain and document the chain of custody for evidence;
- $ maintain the integrity of the evidence to ensure that optimal results are obtained from any subsequent laboratory examination;
- $ evaluate the possibility of pregnancy and discuss treatment options;
- $ evaluate the possibility of sexually transmitted disease, collect appropriate specimens, and provide prophylactic treatment according to the age of the patient;
- $ identify and document injuries;
- $ interpret physical findings;
- $ collect toxicology and reference samples;
- $ recognize conclusions and limitations in the analysis of findings;
- $ complete the standard state forms for documenting the forensic medical results of the exams;
- $ implement a quality assurance program;
- $ inform law enforcement about items connected with the assault which may be at the crime scene, e.g. wipes, lubricants, towels, condoms, etc.; and
- $ discuss findings and assessments with law enforcement and social service investigators and attorneys.

See **Appendix B** on how to contact the California Medical Training Center for information on courses.

CHAPTER IX

ADDITIONAL KNOWLEDGE AND SKILLS NEEDED BY MEDICAL PERSONNEL IN THE PERFORMANCE OF CHILD SEXUAL ABUSE EVIDENTIAL EXAMINATIONS

Standard curriculum has been developed by the California Medical Training Center for training pediatric sexual assault forensic examiners. Advanced and specialized courses are under development. The statements listed below are brief summaries of course objectives.

A. KNOWLEDGE

Medical personnel performing evidentiary examinations must be knowledgeable about:

- common interpersonal dynamics involved in the sexual abuse of children and adolescents, and potential outcomes related to victimization;
- how sexual abuse may effect children's and adolescents' behavior at different developmental stages;
- how a child's or adolescent's reaction to sexual abuse may effect their response to the medical evaluation, the most common fears and concerns they have regarding their own body following sexual abuse;
- psychological approaches that may be used in preparing a child or adolescent for the medical evaluation;
- common fears a family member may have regarding the medical evaluation;
- psychological approaches that may be used in preparing a family member for the child's or adolescent's medical evaluation;
- health professionals' responsibilities as "mandated reporters";
- the roles of law enforcement, child protective services, rape crisis centers, deputy district attorneys, and crime laboratories; and
- how to identify a consultative network for on-going peer review of medical evaluations and interpretation of findings.

B. SKILLS

Medical personnel must be able to:

$ conduct a developmentally appropriate forensically defensible interview of the child or adolescent;

$ perform a general physical examination for the detection of physical findings;

$ use enhancement techniques for detection and documentation of findings, e.g., colposcopy and forensic photography;

$ perform a comprehensive, sensitive, multi-method examination of the ano-genital regions of the child or adolescent;

$ utilize ancillary examination techniques such as saline, vital dyes, and Foley

catheters when indicated;

- $ recognize the physiologic changes, including the Tanner Stages of secondary sexual development that occur as a result of hormonal influences in both males and females;
- $ identify the more common variations of normal and abnormal ano-genital physical findings of a child or adolescent;
- $ recognize the current state of tissue changes that occur as a result of the healing process of any ano-genital injuries encountered;
- $ use appropriate terminology in recording findings and interpretations on forensic medical report forms;
- $ how to obtain both crisis intervention and longer term mental health counseling;
- $ how to appropriately debrief the child or adolescent and family members and address their concerns following the medical evaluation; and
- $ how to testify effectively as an expert witness.

See **Appendix B** on how to contact the California Medical Training Center for information on courses.

CHAPTER X

IMPORTANT CONSIDERATIONS IN THE COLLECTION AND PRESERVATION OF EVIDENCE

Crime Laboratories

Crime laboratories analyze and interpret evidence collected during the forensic medical examination of sexual assault and child sexual abuse victims. There are 31 public crime laboratories in California: 19 city and county laboratories and 12 California Department of Justice laboratories. There are also a number of privately operated crime laboratories. Crime laboratories have slightly different requirements for the collection and disposition of some types of evidence. These situations are identified on the OCJP 923, OCJP 930, and OCJP 950 forms and in this document. (The OCJP 925 is a non-acute forensic exam form, which does not involve collection and preservation of evidence.) It is important to have open communication with your local crime laboratory to ensure that evidence is collected according to local policy. See **Appendix G** for a list of California public crime laboratories.

Importance of the Examiner in Recognizing and Collecting Evidence

Examiners who provide care to sexual assault and child sexual abuse patients must have knowledge of the broad spectrum of evidence that may be present in these cases to effectively recognize, collect and preserve evidence for later analysis. This knowledge also allows examiners to explain to the patient what items they are collecting and the reasons why the evidence may be useful.

The assault history is useful to help guide the examiner in the search for potential evidence on the patient's clothing and body. The history also reveals details about items connected with the assault, such as wipes, lubricants, condoms, towels, etc., which were left at the crime scene. These details guide the investigators and criminalists in their examination of the crime scene and the evidence.

Proper collection and preservation of evidence are critical to maintaining the integrity of the evidence and obtaining optimal results from any subsequent laboratory examination. The OCJP 923, OJCP 930, and OCJP 950 forms provide detailed procedures for locating, collecting, preserving, and packaging evidence. The information in this document is intended to supplement the forms.

A. COLLECTION OF EVIDENCE: TIME FRAME GUIDELINES

1. Loss and Degradation of Evidence

Evidence is lost from the body and clothing through a number of mechanisms. For example, biological degradation of some seminal fluid components occurs within the body orifices; semen drains from the vagina or is washed from the mouth;

spermatozoa lose motility; the victim washes or wipes; and/or foreign materials fall from the body and clothing.

Prompt examination of patients is necessary to minimize further loss of sexual assault evidence. Historically, 72 hours has been considered the guideline to use as an outside limit for obtaining sufficient evidence to allow meaningful analysis. The current use of DNA typing, however, may extend that limit due to the stability of DNA and the sensitivity of the tests. A longer collection time may be recommended in the future.

2. Evidence Collection Time Frame Guidelines

Within 72 hours of the incident

Patients must be examined without delay to minimize the loss or deterioration of evidence. A recommended standard of practice for acute sexual assault or child sexual abuse examinations is immediately upon the patient's arrival at the hospital, or within one hour.

- A complete evidential examination that meets the minimum standards established by Penal Code Section 13823.11 must be conducted.
- See **Appendix A** for a copy of the penal code section.
- Use the required state forms (OCJP 923 and OCJP 930) and recommended sexual assault suspect forensic examination form (OCJP 950) to meet these standards.
  - OCJP 923 Forensic Medical Report: Acute Adult/Adolescent Sexual Assault Examination
  - OCJP 930 Forensic Medical Report: Acute Child/Adolescent Sexual Abuse Examination
  - OCJP 950 Forensic Medical Report: Sexual Assault Suspect Examination

More than 72 hours after the incident

- A complete physical examination must be conducted to examine for injuries to the body and genitalia.
- A modified evidential examination may be indicated as some evidence may remain after several days. The examiner should consider factors such as post coital hygiene and the physical activity level of the patient in deciding whether evidence may remain on or in the body. For example, if a nursing home patient is the victim of an assault, both semen and trace evidence may remain past 72 hours. In cases of suspected drug-facilitated sexual assault, urine toxicology samples may be taken within 96 hours after ingestion of the drug. In addition, documentation of assault history and injuries (even though healing), is important for investigative purposes.

3. Non-acute child sexual abuse cases

There is often a delay in reporting cases involving sexual abuse of children. In many cases the reporting delay can be several weeks or months in duration. Although evidence such as semen, fibers, and hairs will no longer be present, information can be obtained from the observation and documentation of healed injuries, presence of sexually transmitted diseases (STDs), and changes in genital structures. In these cases, it is recommended that the child be seen at a facility that specializes in performing these examinations.

- Use the required OCJP 925 Forensic Medical Report: Non-acute Child/Adolescent Sexual Abuse Examination for these evaluations.

B. ENSURING EVIDENCE INTEGRITY

Key components of proper evidence handling are:

• Placing items in appropriate evidence containers;
• Labeling the evidence containers;
• Sealing the evidence containers;
• Storing evidence in a secure area; and
• Maintaining the chain of custody.

1. Appropriate Evidence Containers: Small, Medium, and Large

Items must be packaged to ensure that evidence cannot leak through the container, be lost, or deteriorate. Sexual assault evidence kits are designed to provide appropriate packaging for most types of evidence encountered. Pre-assembled kits containing the necessary items for evidence packaging can be obtained from the local crime laboratory or purchased from vendors. Contact the crime laboratory for vendor sources.

Common components of sexual assault evidence collection kits:

• **Slide mailers**	To protect slides.
• **Bindles and other small containers**	To protect items that can be easily lost such as crusted materials, soil, and small fibers. Bindles and other small protective containers are then placed into the evidence collection envelopes or boxes described below.
• **Envelopes or boxes**	To protect evidence such as swabs, reference hair samples, and foreign materials, and to hold the small containers listed above.
• **Sexual assault evidence kit container**	A larger envelope or box to hold the individual evidence collection envelopes, small boxes, and slide mailers. The outside of the sexual assault evidence kit container must have a chain of custody form printed on it or securely attached.
• **Paper bags**	To hold clothing

The following chart, not meant to be all-inclusive, is a list of suggested containers for different types of evidence:

Items	Suggested Containers
• Swabs (dried)	• Envelopes • Boxes See **Section I: Biological Samples - Drying and Storing**
• Slides (dried)	• Slide mailers
• Large foreign materials, e.g., hairs, grass	• Envelopes
• Small or loose foreign materials, e.g., soil, paint, splinters, glass, fibers	• Blindles placed into envelopes • Tapelifts in clear plastic containers
• Matted head, facial, or pubic hair bearing crusted material	• Bindles placed into envelopes
• Fingernail scrapings or cuttings	• Paper bindles placed into envelopes • Sealable boxes
• Pubic hair combings	• Paper placed under the patient's buttocks, folded with comb/brush inside, and placed in an envelope
• Pubic, head, and facial (for males) hair reference samples from patients • Pubic, head, facial, and chest hair reference samples from suspects	• Envelopes
• Reference blood samples, liquid	• Lavender and/or yellow stoppered evacuated blood collection vials (according to local policy) placed in envelopes
• Saliva reference sample (dried)	• Envelopes
• Clothing	• Paper bags (not plastic) See **Section C: Collection of Clothing**
• Toxicology samples Blood alcohol/toxicology Urine toxicology	 • Gray stoppered evacuated blood collection vials • Tightly sealed clean plastic or glass container for urine samples See **Section J: Toxicology**

2. Labeling Evidence Containers

All items of evidence must be clearly labeled to enable the person who collected the evidence to later identify it in court and to ensure that the chain of custody is maintained. Many emergency departments use addressograph machines or computerized label generators to expedite labeling of evidence.

Label swabs, slides, bindles and small containers with the following information:

• full name of patient;
• brief description of the source (for example, vaginal swab, vaginal dry mount slide, vaginal wet mount slide, oral swab, oral dry mount slide, crusted material from right thigh, etc.); • the legend locator number can be substituted for the source description, if the legend on the standard form is used to document the location from which the evidence was collected; and,
• a code for swabs and slides to show which slides were prepared from which swabs.
• **Note:** label swabs, slides, blindles, and small containers **before** they are placed into evidence collection containers.

Label envelopes or boxes with the following information:

• full name of patient;
• date of collection;
• description of the evidence including the location from which it was collected;
• signature or initials of the person who collected the evidence and placed it in the container; and
• the legend locator number, if the legend on the standard form is used to document the location from which the evidence was collected.

Sexual Assault Evidence Collection Kit:

• Place all containers, envelopes, and boxes in the Sexual Assault Evidence Collection Kit.
• Complete the chain of custody form preprinted on the kit or securely attach a chain of custody form. • See **Appendix H: Chain of Custody Form.**

3. Sealing evidence containers

Evidence must be packaged in containers that are properly sealed. Proper sealing of containers ensures that contents cannot escape and that nothing can be added or altered.

Proper sealing of evidence containers can be accomplished by:

$ securely taping the container (do not lick the adhesive seal); and
• initialing and dating the seal by writing over the tape onto the evidence container. See **Appendix I: Sealed Evidence Envelope** for an example of proper sealing.
• **Note:** Stapling is not considered a secure seal.

4. Storing evidence in a secure area

Evidence must be kept in a secure area when not directly in the possession of a person listed in the chain of custody.

5. Maintaining the chain of custody

The chain of custody documents the handling, transfer, and storage of evidence beginning with the collection of the evidence at the medical facility. It continues with each transfer of the evidence to law enforcement, the crime laboratory, and others. Complete documentation of the chain of custody information ensures there has been no loss or alteration of evidence prior to trial.

All transfers of evidence must be documented with the following information:

$ name of person transferring custody;
$ name of person receiving custody; and
$ date of transfer.
• **Note:** Some jurisdictions also require documentation of time of evidence transfer. Consult your local crime laboratory for their requirements.

Chain of custody information can be:

$ printed by hand on an evidence envelope or box;
$ securely attached to an evidence envelope or box; or
$ preprinted on special envelopes, boxes and/or forms.
• For examples of a chain of custody form and an example of a properly sealed chain of custody envelope, refer to the following: **Appendix H: Chain of Custody Form** **Appendix I: Sealed Evidence Envelope.**

C. COLLECTION OF CLOTHING

$ Collect clothing worn by the patient upon arrival at the hospital for acute sexual assault examinations.
$ Provide a change of clothing to minimize the loss and/or contamination of potential evidence on the clothing. Coordination between the hospital, friends, relatives, and/or the local rape crisis center is recommended to address this need.
$ For non-acute child sexual abuse examinations (over 72 hours), clothing does not need to be collected.

1. Types of evidence on clothing

Clothing worn at the time of the assault may contain useful evidence:

- $ rips, tears or other damage sustained as a result of the assault;
- $ biological stains, such as blood, semen or saliva from the suspect;
- $ blood and other body fluids from the patient;
- $ pubic, head, facial or body hair foreign to the patient; and/or
- $ foreign materials such as fibers, grass, soil, and other debris from the suspect or the crime scene.

Clothing worn after the assault may also hold valuable evidence:

- $ semen may drain from the vagina onto the underwear; and
- $ hairs and foreign materials may transfer from the patient's body to the clothing.

2. Collection procedures

Procedures for the proper collection and packaging of clothing are described on the OCJP 923, OCJP 930, and OCJP 950 forms and instructions. Additional information is provided below.

- $ **Have patients remove their shoes first, then disrobe on two sheets of paper placed on top of one another on the floor.**
  The purpose of the bottom sheet is to protect the top sheet from dirt and debris on the floor. The purpose of the top sheet is to collect loose trace evidence which may fall from the clothing during disrobing. The disposable paper used on examination tables is acceptable for this purpose.

- $ **Shoes**
  The shoes may be collected and packaged separately, if requested by the investigating agency or if indicated by the assault history. For example, shoes should be collected if the suspect bled on the shoes or the patient left shoe prints at the crime scene.

- $ **Hairs, fibers, and debris**
  Collect loose hairs, fibers, and debris (which fall from the clothing) in the top sheet of paper placed on the floor for this purpose. After the clothing has been collected, fold the top sheet of paper (from the two sheets on the floor) into a large bindle to ensure that all foreign materials are contained inside. Label and seal to ensure that the contents cannot escape. Place into a large paper bag. The bottom sheet should be discarded.

- $ **Seminal fluid**
  Give special focus to items that are close to the genital structures or otherwise have the highest potential to contain seminal fluid according to the assault history. If, for example, ejaculation occurred on the patient's chest, semen may be found on a shirt worn during or immediately after the assault. According to local policy, these items may be placed in the evidence kit.

- $ **Folding garments**
  Fold each garment as it is removed to prevent body fluid stains or foreign materials from being lost or transferred from one garment to another. Avoid folding the clothing across possible body fluid stains.

- $ **Wet clothing**
  It is preferable to dry clothing before packaging. If drying is not possible, wet clothing can be folded sandwiched between sheets of paper. After placing the item in a paper bag, clearly label the bag as containing a wet item and notify the law enforcement officer. Consult your local crime laboratory for additional recommendations.

- $ **Containers for clothing**
  Package each item of clothing in an individual paper bag. **Do not use plastic bags.** Plastic retains moisture which can result in mold and deterioration of biological evidence.

3. **Securely seal and label each clothing bag with the following:**

$ full name of patient;
$ date of collection;
$ brief description of item; and
$ signature or initials of the person who collected the evidence and placed it in the container.

4. **Place small bags of clothing and the large paper bindle (from the floor) into large bag(s)**
   Place all bags (except those containing wet evidence) and the bindle made from the top sheet of paper into a large paper bag which has a chain of custody form printed on it or firmly attached. Multiple large bags may be used, if necessary.

D. USE OF THE WOOD'S LAMP OR OTHER ALTERNATE LIGHT SOURCES FOR COLLECTION OF SECRETIONS AND/OR FOREIGN MATERIALS

A visual examination of the patient's body and hair can be aided with the use of a longwave ultraviolet light, commonly known as a Wood's lamp. Other light sources which provide alternate wavelengths of light can also be used. These lights are used to scan the body for evidence such as:

$ dried or moist secretions;

$ fluorescent fibers not readily visible in room light; and

$ subtle injury.

1. Areas to examine

Use these lights in a darkened room to examine the patient's entire body. Take care to protect the patient's eyes when using ultraviolet light. Specifically examine these areas of the body:

$ head, face, hair, lips, perioral region, and nares;

$ chest and breasts;

$ external genitalia, perineal area, inner thighs, and pubic hair;

$ buttocks, skin, and anal folds; and,

$ any area indicated by the patient's history.

2. Detecting semen

- Dried semen stains have a characteristic shiny appearance and tend to flake off the skin.

$ Semen may exhibit an off-white fluorescence under ultraviolet light.

$ Fluorescent areas may appear as smears, streaks, or splash marks.

$ Moist or freshly dried semen may not fluoresce.

3. Collection of semen

• Swab each suspicious area, whether detected visually or indicated by the patient's history, whether it fluoresces or not, with separate swabs moistened with sterile, deionized, or distilled water.
• Collect the entire stain using several swabs, if necessary.
• Collect control swabs. Label and package evidence and control swabs in separate packages. See **Section G2. Collection of Control Swabs**
• **Note:** The appearance of fluorescent areas does not confirm the presence o semen, as other substances such as urine or body lotions may also fluoresce. Independent confirmation of these findings by the crime laboratory is required.

$ For further information on biological samples, refer to the following**:** **Section F Biological Evidence: General Information** **Section G Biological Evidence: Collection of Samples from the Head, Hair, and Body** **Section H Biological Evidence: Collection of Oral, Vulvar, Vestibular, Vaginal, Cervical, Anal, Rectal, Penile and Scrotal samples**

4. Detecting subtle injury

Rope marks, bite marks, recent contusions, and other subtle injuries may be more visible with the aid of the Wood's Lamp or other alternate light source.

E. COLLECTION OF FOREIGN MATERIALS

1. Types of foreign materials:

• fibers;	• soil;
• hairs;	• sand;
• paint;	• glass; and
• grass or other vegetation;	• other debris.

2. Important comparisons of foreign materials:

$ foreign materials collected from the patient's body, fingernails, and clothing can be compared to similar evidence collected from the suspect or crime scene;
$ pubic, head, facial, or body hair collected from the patient's body and/or clothing can be compared to reference hairs obtained from the patient. Hairs found to be foreign to the patient can then be compared to reference hairs obtained from potential suspects.

3. Analysis of foreign materials may:

$ help establish a connection between the patient and the assailant and/or the crime scene;
$ provide information regarding the circumstances of the assault; and
$ provide other valuable investigative information.

4. Collection methods for foreign materials:

Items	Collection method(s)	Container(s)
Fingernail scrapings	$ Use clean toothpicks or manicure sticks to collect scrapings from under the fingernails. Place scrapings from each hand into separate containers; OR $ Use a clean fingernail cutter or scissors to cut the fingernails. Place cuttings from each hand into separate containers or bindles.	• Paper bindle for each hand; or • Sealable boxes for each hand
Large foreign materials, e.g., hairs, grass	$ Collect materials with forceps.	• Envelopes
Small or loose foreign materials, e.g., fibers, paint, splinters, glass	• Remove with forceps; OR • Gently scrape the materials with a clean slide or back of scalpel blade; OR • In the case of fiber evidence, collect with transparent tape. Use the sticky side of a piece of transparent tape to remove the materials from the surface. Place the tape (sticky side down) onto a transparent material, such as a zip-lock plastic bag turned inside out. Turn the bag right side out and seal to prevent the contents from escaping. • The adhesive in products such as "Post-It Notes" works well to remove small materials from the ends of the forceps. Fold the Post-It Note into a bindle.	• Paper bindles • For tapelifts: use zip-lock plastic bags or other transparent containers that can be sealed.
Dried soil	• Gently scrape the materials with a clean slide or the back of a scalpel blade.	• Paper bindle
Matted head, facial, or pubic hair bearing crusted material	• Cut with a pair of clean scissors.	• Paper bindle
Pubic hair combings or brushings	• Place a paper sheet under the patient's buttocks. Comb the pubic hair downward to remove loose hairs and/or foreign materials. Fold the paper into a bindle with the comb or brush inside.	• Paper bindle
Note: Place bindles and other small protective containers into the evidence collection envelopes.		

F. BIOLOGICAL EVIDENCE: GENERAL INFORMATION

1. Collection of biological evidence

Collect biological evidence based on the visual and Wood's Lamp examination and the patient's history**.** The patient history may lead the medical examiner to biological evidence that is not otherwise visible.

2. Types of biological evidence

Biological evidence includes samples such as:

- $ semen;
- $ blood;
- $ vaginal secretions;
- $ saliva (from bites, "hickeys", licking and kissing); and
- $ vaginal epithelial cells recovered from the suspect's genitals or from condoms.

The crime laboratory examines the following items for biological evidence:

- $ patient's clothing;
- $ swabs of dried and moist stains from the patient's body, head, and hair;
- $ vulvar, vestibular, vaginal, cervical, oral, anal, and/or rectal swabs and slides;
- $ cuttings of matted hair;
- $ pubic hair combings;
- $ fingernail scrapings; and
- $ swabs of the suspect's genitalia.

The body fluid(s) present in these samples can be identified and genetically typed by the crime laboratory. The information derived from the analysis can be used to:

- $ determine whether sexual contact occurred;
- $ provide information regarding the circumstances of the incident; and
- $ compare to reference samples collected from victims and suspected assailants.

3. DNA typing

DNA typing has revolutionized the analysis of biological evidence. It is now possible to obtain very discriminating information from a wide variety of biological evidence. This information allows evidence collected from the patient, suspect, or crime scene to be linked. In addition, DNA testing is now sufficiently sensitive that valuable genetic information can be routinely obtained from very small or old evidence samples. A much higher success rate is now possible for typing small evidence samples such as fingernail scrapings, vulvar, vestibular, penile/scrotum swabs, and saliva samples from areas where a victim was licked or kissed. Along with the increased sensitivity of DNA testing, however, comes a heightened concern regarding the possibility of contaminating evidence samples. It is important that anything (implements, gloves, etc.) used to collect or hold samples be adequately cleaned between samples. See the following section on handling.

The other major advancement is the ability to use DNA typing results as an investigative tool to identify potential assailants in sexual assault investigations. The California Department of Justice DNA Laboratory maintains a databank of DNA profiles from convicted offenders. It is now possible to search a DNA profile from an evidence sample (collected from a patient or crime scene) against a databank to help identify the perpetrator of a crime. This means that DNA results can be used much like fingerprints to help solve violent crimes in California.

4. Handling to avoid contamination

It is important to avoid contamination of any evidence. Particular care must be taken when collecting evidence for possible DNA analysis because DNA analysis is extremely sensitive and allows typing of very small samples.

Contamination can originate from or be transferred from:

$	the examiner to the patient;
$	the examination environment to the patient; or
$	from one piece of evidence to another.

The following is a list of suggested practices to prevent contamination:

$	Wear gloves and change as needed;
$	Thoroughly clean the examination area and evidence processing areas between examinations;
$	Package unlike samples separately;
$	Package samples from different patient examinations separately; and,
$	Avoid contamination during the drying of samples See **Section I Biological Samples: Drying and Storing**.

G. BIOLOGICAL EVIDENCE: COLLECTION OF SAMPLES FROM THE HEAD, HAIR AND BODY

1. Collection of samples

$ Collect dried and moist secretions and stains from the patient's head, hair, scalp, and body. Examples include semen, blood, and saliva from bites, suction injuries (hickeys), licking, and kissing.

- Use a Wood's Lamp (longwave ultraviolet light) or alternate light sources to assist in identifying secretions and stains. See **Section D: Use of the Wood's Lamp or Other Alternate Light Sources for Collection of Secretions and/or Foreign Materials.**

$ Swab each moist stain with a dry swab to avoid dilution. Collect the entire stain, using several swabs if necessary.
$ Collect each dried stain with a swab moistened with sterile, deionized, or distilled water. Collect the entire stain, using several moistened swabs if necessary. Small packages of sterile water are available through medical supply vendors.

2. Collection of control swabs

The control swab provides the crime laboratory with "baseline" information regarding the patient's own secretions or possible contaminants adjacent to the stained area. The analyst uses information developed from analysis of the control swab to interpret the typing results from the evidence swab.

$ Collect a control swab by moistening a swab with sterile, deionized, or distilled water and swab an unstained area <u>adjacent</u> to the stain. For example, if the stain is on the right arm, collect the control swab from an unstained area near the stain on the same arm.
$ Collect one control swab for each stain collected, unless several stains are collected within a small area. In that case, one control swab is sufficient.
• Carefully label the control and evidence swabs, air dry, and package them in separate containers.

3. Collection of matted hair

Cut matted head, facial, pubic, or body hairs bearing crusted material and place in a bindle. These samples may consist of undiluted semen and can be a valuable source of genetic information regarding the suspect.

All swabs and slides must be air dried prior to packaging (Penal Code Section 13823.11).

H. BIOLOGICAL EVIDENCE: COLLECTION OF ORAL, VULVAR, VESTIBULAR, VAGINAL, CERVICAL, ANAL, RECTAL, PENILE AND SCROTAL SAMPLES

1. Collection of oral samples

Since mixtures of semen and saliva may be present in the perioral area, examine this area carefully and sample as appropriate. Semen is rapidly lost from the mouth by dilution with saliva, swallowing, eating, and drinking.

Oral Swabs
$ If less than 12 hours have passed since the incident, collect two swabs by swabbing firmly around the gums, frenulums, and in the fold of the cheek.
$ Prepare one dry mount slide from one of the swabs. See **Section H.5** for preparation of dry mount slides.

All swabs and slides must be air dried prior to packaging (Penal Code Section 13823.11).

2. Collection of vaginal and cervical samples from adults and older adolescents

Examination of the vulvar (labia majora), vestibular (labia minora), vaginal, and cervical areas may reveal foreign materials such as hair, vegetation, and foreign bodies. These items should be collected prior to collection of swabs from the vagina and cervix.

Vaginal Swabs
$ Collect four vaginal swabs.
$ Prepare one dry mount slide and one wet mount slide.
$ Label swabs. Code swabs and slides to show which swabs were used to make which slides.
$ See **Section H.5** for preparation of a dry mount slide.
$ See **Section H.6 and H.7** for preparation of wet mount slides.

Spermatozoa can be recovered from the cervix for longer periods of time than in the vaginal vault.

• If 48 hours or more have passed since the incident, collect two cervical swabs in addition to the vaginal swabs.
• Label cervical swabs to distinguish them from vaginal swabs.

3. Collection of wipes and tissues

The patient may have wiped her mouth, genitals, and/or body with tissue, wipes, or clothing after the assault. If available, collect these items. If not, notify law enforcement so these items can be collected.

All swabs and slides must be air dried prior to packaging (Penal Code Section 13823.11).

CHILDREN AND YOUNG ADOLESCENTS

4. Collection of genital swabs from children and young adolescents

Sexual development and the size of the hymenal orifice must be considered in the examination of children and young adolescents.

Prepubertal girls	**Speculum exams**	**THIS IS NOT DONE.**
	Swabs	• Collection of intra-vaginal swabs is rarely done on prepubertal girls. • If the hymenal diameter is not large enough to insert a swab without touching the hymen, then vaginal swabbing SHOULD NOT be done.
	Collect vulvar and vestibular swabs.	• Assaults on prepubertal children often include oral contact or rubbing the penis on the genital structures instead of penetration. The genital area must be swabbed to collect possible saliva or semen regardless of Wood's Lamp findings.
	Vulvar swabs	• Collect at least two vulvar (labia majora) swabs. Label swabs.
	Vestibular swabs	• Collect at least two vestibular (labia minora) swabs. Label swabs.
Postpubertal girls	**Speculum exams**	Use appropriate size speculum.
	Vaginal swabs	Collect four swabs **ONLY** if size and sexual development permits. $ Prepare one wet mount slide. $ Prepare one dry mount slide. $ Label swabs. $ Code swabs and slides to show which swabs were used to make which slides.
	Cervical swabs	If 48 hours or more post assault, collect 2 cervical swabs only if a speculum can be used without causing trauma. Label swabs.

All swabs and slides must be air dried prior to packaging (Penal Code Section 13823.11).

5. Preparation of a dry mount slide

• Dry mount slides are used by the crime laboratory to detect the presence of sperm.
• Select one of the swabs collected from the vaginal pool. Roll the swab in a rotating motion to make a thin smear on the slide.
• Label, air dry, package, and seal.
• Label the swab used to make the dry mount slide so that the crime laboratory knows it was used for this purpose.

6. Preparation and examination of wet mount slide for presence of spermatozoa

$ Wet mount slides are used by the medical examiner to determine the presence or absence of motile or nonmotile sperm in the vagina of the patient.

$ The presence of motile sperm in the vaginal pool is the best indication of recent ejaculation. The absence of motile sperm, however, does not negate the possibility of recent ejaculation as sperm may become non-motile within hours of entering the vaginal environment.

$ Since sperm motility can only be observed on an unstained wet mount slide, the motility examination must be performed under a microscope as a part of the forensic medical examination of the patient.

$ The chance of observing motile sperm can be improved by using a phase contrast or other "optically staining" microscope, and by prompt examination.

$ The wet mount slide has evidential value and must be retained and submitted along with other evidence collected from the patient. Even when sperm are not observed initially in the motility examination, they may be detected during subsequent examination of the dried and stained smear by the crime laboratory.

$ See detailed preparation procedures on the next page.

All swabs and slides must be air dried prior to packaging (Penal Code Section 13823.11).

7. Prepare and observe a wet mount slide as described below:

$ Label a slide as "wet mount" and include the patient's name.
$ Place a drop of normal saline or buffered nutrient medium on the slide to preserve the motility of the sperm. A glucose fortified solution of balanced salts, such as Ringer's, Tyrode's, or Dulbecco's at normal osmolality, pH 7.2-7.4 is recommended. Prepared solutions of media designed to enhance sperm survival during microscopic examinations are commercially available.
$ Select one of the swabs collected from the vaginal pool and roll the swab back and forth in the drop to transfer cellular debris to the medium. Place a cover slip on the slide.
$ Examine the wet mount slide within 5 to 10 minutes using a biological microscope at 400 power, or by using a phase contrast or other "optically staining" microscope to determine whether or not motile or non-motile sperm are present.

$ If the medical examiner is unable to evaluate the wet mount slide for sperm motility:
$ the clinical laboratory must perform the motility exam within 5-10 minutes of slide preparation; and
$ the medical examiner must ensure that the chain of custody is maintained and documented.

$ Label and air dry the swabs and slide; do not remove the cover slip. Label the swab used to make the wet mount slide so that the crime laboratory knows it was used for this purpose.

All swabs and slides must be air dried prior to packaging (Penal Code Section 13823.11).

8. Collection of anal/rectal samples

Perianal Area and Anal Region
• Examine the buttocks, perianal area, and anal region for foreign materials such as lubricants, vegetation, hair, and semen.
• Collect these samples and take photographs of the area prior to collection of anal/rectal swabs.
• **Females:** semen may be present in the perianal area from vaginal drainage. Avoid contaminating anal/rectal swabs by cleansing the perianal area after external secretions and foreign materials have been collected. Use sterile, deionized, or distilled water.
• **Males:** avoid contaminating anal/rectal swabs by cleansing the perianal area after external secretions and foreign materials have been collected. Use sterile, deionized, or distilled water.

Anal/Rectal Swabs
For Adults and Older Adolescents
$ If the history indicates, collect two rectal and/or anal swabs and prepare one dry mount slide.
$ If anal penetration is alleged, the most reliable swabs will be obtained from the rectum using an anoscope after perianal cleansing. These swabs should be obtained by direct visualization from the rectal mucosa visible above the tip of the anoscope. $ If the patient is unable to tolerate a water moistened anoscope or anal speculum: ➢ Lightly coat the instrument with lidocaine jelly; or, ➢ Use manual traction and obtain samples from the anal canal.

For Children and Young Adolescents
• If the history indicates, collect two anal and/or rectal swabs and prepare one dry mount slide.
$ An anal speculum is not recommended for use with children.
$ Use lateral traction on the buttocks or the knee-chest position with lateral traction on the buttocks.
• If an anoscopic examination is medically indicated, document under examination methods. Sedation or anesthesia is recommended for the prepubertal child.

All swabs and slides must be air dried prior to packaging (Penal Code Section 13823.11).

9. Collection of penile and scrotal swabs from male victims

Collect penile and scrotal swabs if the assailant orally copulated a male victim because saliva may be found that can be typed and linked to the assailant.

Penile Swabs
$ Collect two penile swabs, if indicated by history.
$ Hold two swabs moistened with sterile, deionized, or distilled water together as a unit.
$ Swab the glans, shaft, and base of the penis with a rotating motion to ensure uniform sampling.
$ Avoid swabbing the urethral meatus.

Scrotal Swabs
$ Collect two scrotal swabs, if indicated by history.
$ Hold two swabs moistened with sterile, deionized, or distilled water together as a unit.
$ Swab the scrotal area, focusing on the area that is in closest proximity to the penis, with a rotating motion to ensure uniform sampling.

All swabs and slides must be air dried prior to packaging (Penal Code Section 13823.11).

I. BIOLOGICAL SAMPLES: DRYING AND STORING

1. Drying biological samples

$ **Swabs, slides, and saliva reference samples**

All swabs and slides must be air dried prior to packaging (Penal Code Section 13823.11). Biological evidence is best preserved by rapid drying and storing frozen. This prevents deterioration of biological evidence and helps preserve it for later typing and comparison with potential suspects.

$ Complete drying of a saturated swab requires at least one hour in a stream of cool (not heated) air. For best results, use a swab drying box.
$ If samples are left unattended during the drying process, the chain of custody must be maintained by using a swab drying box with a lock, or by securing it in a locked cabinet. The locks used to secure "crash carts" are recommended for this purpose.
$ Only dry the swabs from one patient at a time in the swab drying box to prevent sample contamination. Leave adequate space between the swabs in the box whenever possible.
$ Wipe or spray the swab drying box with 10% bleach before each use.
$ Drying boxes can be purchased. Contact your local crime laboratory for vendor sources. See **Appendix K** for specifications for making a swab drying box.

$ **Contraceptive devices and feminine hygiene products**

Other specimens may be encountered during an examination, for example, tampons, sanitary napkins, tissues, diaphragms, and condoms.

$ Air dry these specimens for at least one hour or longer when possible.
$ If the item is still damp, fold it loosely in paper and package it in a paper envelope, bag, or box.
$ Clearly label the envelope, bag, or box as containing a damp item, e.g., "wet evidence" and notify the law enforcement officer.
$ Consult your local crime laboratory as they may have special kits or special handling procedures for collection of these items.

2. Storing biological samples

$ **Freezer**

Ideally, dried swabs and clothing stained with blood and/or other body fluids should be stored frozen. This is ordinarily the responsibility of the local law enforcement agency. Follow procedures recommended by the local crime laboratory.

$ **Refrigerator**

If evidence pickup will be delayed, it is recommended that the medical facility refrigerate liquid blood samples to prevent deterioration. Do not freeze liquid blood. Freezing will lyse (burst) the blood cells and may break the vials.

J. TOXICOLOGY

In addition to clinical implications, the presence of alcohol and/or drugs in the patient's blood or urine may have legal significance. The assailant may have used drugs to subdue the victim. The victim may have lost the ability to make rational decisions, lost consciousness, or may have no recollection of events. Drugs and/or metabolites of drugs such as marijuana, cocaine, methamphetamine, benzodiazepines [including diazepam (Valium) and flunitrazepam (Rohypnol)], and gamma-hydroxybutyrate (GHB) can be detected through testing blood and urine samples. Collect samples in accordance with local policy. See next section for collection procedures

1. Collect toxicology samples if the patient:

$	is unconscious;
$	exhibits abnormal vital signs;
$	reports ingestion of drugs or alcohol;
$	exhibits signs of memory loss, dizziness, confusion, drowsiness, impaired judgment;
$	shows signs of impaired motor skills;
$	describes loss of consciousness, memory impairment or memory loss; and/or
$	reports nausea.

2. Use these containers for toxicology samples:

Blood samples	Gray stoppered evacuated blood collection vials
Urine samples	Tightly sealed clean plastic or glass container
Note: Refrigeration of toxicology samples is recommended.	

3. Collect toxicology samples as soon as possible

Alcohol metabolizes rapidly. Many drugs are also quickly eliminated from the body.

For alcohol analysis, collect a blood sample (5cc).
$ Some drugs may also be detected in this sample if it is collected within 24 hours of ingestion. If this is a consideration, collect 30cc of blood for drug analysis.
$ Be sure to cleanse the arm with a non-alcoholic solution.

If ingestion of drugs is suspected within 96 hours of the examination, collect the first available urine specimen (100cc).
$ If the patient must urinate prior to the forensic medical examination, the urine specimen for toxicology should be collected at that time.
$ "Clean catch" or "mid-stream" sampling methods are unsuitable for urine toxicology specimens.
$ Consult your local crime laboratory for recommended collection methods.

K. REFERENCE SAMPLES

Reference samples are used by the crime laboratory to determine whether or not evidence specimens collected are foreign to the patient.

1. Time and manner of collection

The time and manner of collection of reference samples varies according to local crime laboratory procedures. Some crime laboratories require collection of reference samples at the time of the forensic medical examination and others allow collection at a later time. Consult local policy.

2. Types of reference samples

$ **Saliva reference sample**

Historically, saliva reference samples have been required for the interpretation of ABO typing results. With the use of DNA typing, this sample may not be needed. Consult your local crime laboratory. If the laboratory requests the saliva reference sample, collect it whether an oral assault occurred or not. Collect a saliva reference sample by placing two swabs in the mouth and allowing them time to saturate.

$ **Liquid whole blood samples**

Collect blood samples in lavender and/or yellow stoppered evacuated blood drawing vials, or use blood cards as specified by local policy.

These colored vials contain the preservatives suitable for forensic blood typing and will be specified by the local crime laboratory. Do not substitute other containers. Vials containing liquid blood samples should be refrigerated, not frozen.

Many of the samples collected in a forensic medical examination contain a mixture of secretions. For example, a vaginal swab found to have semen present would also contain vaginal secretions from the patient. To interpret the genetic typing results obtained from this swab, it is essential to know the genetic profile of the patient. The blood reference sample from the patient is used for this purpose.

$ **Buccal (inner cheek) swabs as a DNA reference sample**

In some cases it may be more appropriate to collect a buccal swab reference sample for DNA typing than a blood sample. Examples include cases involving very young children from whom it is difficult to obtain blood, patients who will not allow a blood sample to be drawn, and suspects.

Rub two swabs gently but firmly along the inside of the cheeks, rotating to ensure even sampling. Dry, package, label, and seal. Clearly label these as buccal swab reference samples for DNA typing. Buccal swabs are not suitable as reference samples for conventional typing methods. Consult your local crime laboratory for further information.

$ **Hair reference samples**

The decision to pluck or cut hairs should be made in conjunction with your local crime laboratory. Plucking hairs can be uncomfortable. Plucked hairs are, however, more reliable as reference samples as they permit evaluation of the hair length and variation of natural pigmentation or dyes from the root to the tip. Some hospitals have found that allowing the patient to pull the hairs is a more comfortable alternative.

Due to the variations in an individual's hair growth, it is necessary to collect a sample representative of these variations. Twenty to thirty hairs representing different sections of the growth area are needed to provide an adequate sample for forensic analysis.

Pubic and head hair reference samples obtained from the patient can be compared to hairs collected from his or her body and clothing. Hairs found to be foreign to the patient can then be compared to reference hairs obtained from potential suspects.

L. PROCEDURES FOR BITE MARKS

1. Photographing bite marks

Individuals can be identified by the size and shape of their bite marks. Properly taken photographs of bite marks and bruises can assist in the identification of the person who inflicted the injury. See Chapter XI on Photography.

2. Collecting saliva from bite marks after photodocumentation

This sample can be examined by the crime laboratory for the presence of saliva and can be genetically typed and compared to potential suspects. Follow these procedures:

$ Swab the general area of trauma with a swab moistened with distilled, deionized or sterile water.
• **Note:** If the patient history indicates a bite and there are no visible findings, swab the indicated area.
$ Collect a control swab from an unbitten atraumatic area adjacent to the suspected saliva stain.
$ Label, air dry, and package the evidence and control swabs separately.

3. Casting bite marks

$ If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.

$ A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.

$ Bite marks may not be obvious immediately following an assault, but may become more apparent with time. A recommendation should be made to the law enforcement agency to arrange for follow-up inspection within one to two days and to have additional photographs taken.

M. BRUISING AND AGING OF INJURIES

Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages.

$ Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.

$ Deep tissue injuries may not be seen or felt initially.

$ Arrange or recommend to the law enforcement agency to have follow-up photographs taken in one to two days after the bruising develops more fully.

N. USE OF TOLUIDINE BLUE DYE

Toluidine blue dye is used to assist in the identification of recent genital and perianal injuries. The application of a 1% aqueous solution of Toluidine blue dye and its subsequent removal with a lubricant, such as K-Y jelly or a 1% acetic acid solution, has been shown to increase the detection rate of posterior fourchette lacerations from 16% to 40% in adult rape victims. This vital dye, which will stain the exposed nuclei of injured tissues, will not distinguish between the superficial lacerations that may occur during consensual intercourse and those found following a sexual assault. This is particularly true in the adolescent patient. The dye may also be picked up by the inflammatory response of benign or malignant vulvovaginal disease. In these situations, the uptake will appear as a diffuse pattern.

Advisory: Record observations, take colposcopic photographs, and collect swabs before using Toluidine blue dye.

CHAPTER XI

PHOTOGRAPHY

A. POLICIES AND CONSIDERATIONS

Photographs are recommended to supplement documentation of history and physical findings. They may be the only way to adequately document findings such as bite marks, bruises, or massive injuries.

$ Photograph every potentially significant injury or finding.

$ Photographs may be taken by trained medical forensic examination team members or be arranged with the local law enforcement agency.

$ Patients may be concerned about privacy and modesty during photography. Sensitivity to these concerns should be exercised when deciding whether hospital personnel, a male or female law enforcement officer, or crime scene investigator takes the photographs.

$ Patients should be appropriately draped.

B. PHOTOGRAPHIC PROCEDURES

Any good quality camera may be used as long as it can be focused for undistorted, close-up photographs and provides an accurate color rendition.

• Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
• Use adequate lighting whether the source is natural, flood, or flash.
• Take close-up photographs of bite marks and other wounds with the film plane as parallel to the subject area as possible. Minimize tilting of the camera to avoid distortion of the picture.
• Include an accurate ruler or scale for size reference in the photograph. The scale should be in close proximity to and in the same plane as the injury or item being photographed. (A right-angle ruler, available commercially from police supply companies, is recommended. Consult your crime laboratory for vendors).
• Include a color bar in the photograph to ensure accurate color reproduction.
$ Link the patient's identity and the examination date to the photographs of injuries and/or findings. This can be accomplished by: ➢ including a picture of the patient's identification card on the roll; or ➢ using a camera databack that can be programmed with the patient's medical record number or another non-duplicative numbering system.
• Avoid obscuring the injury with the ruler, identification label, or color bar. At least one or two photographs should be taken without the scale and/or color bar to orient the injury and to demonstrate that important evidence was not covered up.
• Additional photographs taken with a tangential light source (flash) may be used to enhance textured or irregular surface findings (e.g. bite marks, focal swelling, etc.).

C. GENERAL FORENSIC PHOTOGRAPHIC TECHNIQUES

At least three photographs of findings are required:

$ "Regional" or "Orientation" photograph(s) showing the body part and the finding. (This shows the finding in the total context of the body region involved, as well as the anatomical orientation of the finding);
$ A close-up shot showing the whole finding; and
$ A second close-up using the scale to document size and camera position relative to the finding.
$ **Note:** These principles may be modified or adapted if multiple findings are in the same area.

CHAPTER XII

COLPOSCOPES

Use of the Colposcope for Evidential Examinations

Pediatricians began to use the colposcope, a common equipment item in gynecologic and primary care clinics, in the early 1980's as a means to detect subtle signs of child sexual abuse. The introduction of the colposcope established the concept of the non-acute sexual abuse examination. This was an important development for children because they are more likely to delay disclosure of sexual abuse than to report it immediately.

The colposcope established a new standard of practice by enabling pediatric examiners to detect subtle injury and/or healed changes in the genital or rectal area. Its use facilitated the development of standards for evaluating normal and abnormal findings caused by sexual abuse. It is used for both acute and non-acute child sexual abuse forensic examinations.

Colposcopes have magnifying lenses ranging from 4x to 30x power and can have 35 mm camera or video camera attachments. In addition to a light source, colposcopes have a green filter that enhances the visualization of scars, unusual vascular patterns, and genital warts.

In recent years, the colposcope began to be used for acute sexual assault medical forensic examinations. Examiners obtain magnified image examinations of the oral pharynx, genital, and rectal areas. Minor skin and/or mucosal surface trauma such as abrasions, lacerations, petechiae, focal edema, hymenal tears, and anal fissures are more easily seen with magnification, and photographs can be taken for documentation.

Video cameras can be attached to colposcopes to record images. The advantage of videotape is to capture movement, which can illustrate findings better than a still picture. Still pictures can, of course, be produced from videotape images.

CHAPTER XIII

CONSULTATION THROUGH TELEMEDICINE AND TECHNOLOGY

Telemedicine and telecourses are evolving rapidly through technology. Various types and resources are listed below:

A. POTS (PLAIN OLD TELEPHONE SYSTEM) and POMS (PLAIN OLD MAIL SYSTEM)

Telemedicine began with POTS and POMS. Case consultation began through telephone consultation and using the mail system to send photographs of injuries to experts at other locations for assistance in interpretation and case management.

B. TWO TYPES OF VIDEO CONSULTATION: REAL TIME AND STORE AND FORWARD

1. Real Time Consultation

The term "real time" refers to live, clinician to clinician consultation most often between a tertiary hospital and an outlying clinic in a rural area. The rural clinician may need back up in a particular specialty, for example, obstetrics or dermatology. A clinic is scheduled for certain times and days of the week and the tertiary hospital physician is scheduled to consult with the rural clinician at that time. Video cameras are permanently set up and the tertiary center clinician monitors the examination and observes the findings at the same time as the rural clinician.

2. Store and Forward Consultation

The term "store and forward" means to photograph or videotape the examination, to save or "store" the videotape or photograph, and to forward it to a specialist or expert at a tertiary center for consultation. Software exists to transmit photographic and videotaped images over telephone lines. Hardware requirements include a computer, monitor, and VCR at both sites. Confidentiality and the transmission of medical records have been addressed in the development of this software.

Store and Forward has been found to be most practical in the field of forensic medicine to evaluate child abuse and sexual assault cases. First, the timing of forensic exams is unpredictable and given the low volume in rural areas the "scheduled clinic" approach is more difficult to implement. Second, the time demands are high upon the few forensic medical experts in child abuse and sexual assault. A Store and Forward system makes it easier to view transmitted photographs and videotapes on a time schedule that works for the forensic expert. See **Appendix B** on how to contact the California Medical Training Center for further information.

3. Interactive Video Consultation

Video consultation is generally focused on one or more case studies and is handled through point-to-point computer transmissions. This type of consultation is held around a computer monitor and 4-6 professionals (or more depending on the size of the monitor or screen) can be accommodated at each site. Point-to-point refers to a connection between a tertiary hospital and one or more outlying areas. A simultaneous telephone connection on a speaker phone is set up and visual images are transmitted on the computer monitor.

4. Telecourses or Distance Learning Through Satellite Transmissions

These terms are used to refer to courses transmitted simultaneously to different sites to a live audience. A tertiary center broadcasts the course to pre-determined sites.

C. CD ROM COURSES

Reference materials and courses are now being developed on CD ROMs. For example, child sexual abuse medical findings and their interpretation can be obtained on a CD ROM. See **Appendix B** on how to contact the California Medical Training Center for further information.

D. INTERNET

Courses and reference materials are offered through various internet sites and links. Use the various search engines.

CHAPTER XIV

IMPORTANT CONSIDERATIONS IN THE EVALUATION OF CHILDREN

A. TANNER STAGES

- $ See **Appendix L** for photographs of Tanner Stages.
- $ Tanner Stages describe the secondary sexual development of children. These developmental stages are relevant to the interpretation of physical findings in child and adolescent sexual abuse cases. There is a relationship between Tanner Stages and hymenal development. Physical findings must be evaluated in the context of hymenal development for the interpretation of findings. The relationship between hormonal and hymenal changes in infants, however, has not yet been established.
- $ Tanner Staging is also relevant to evaluation of pregnancy risk. All females, Tanner Stage 3 and above, should be evaluated for risk of pregnancy.
- $ **Breast Tanner Stages**
  1. Preadolescent
  2. Breast and papilla elevated as small mound: areolar diameter increased
  3. Breast and areola enlarged, no contour separation
  4. Areola and papilla form secondary mound
  5. Mature: nipple projections, areola part of general breast contour
- $ **Genital Tanner Stages**
  1. No or fine vellus (peach fuzz) hair
  2. Sparse, long straight pigmented hair
  3. Increased density, dark coarse curly hair
  4. Abundant hair, sparing medial thighs
  5. Abundant hair, spreading to medial thighs
- $ Training on Tanner Stages is provided by the California Medical Training Center. See **Appendix B**.

B. TERMS AND DEFINITIONS FOR GENITAL STRUCTURES AND INTERPRETATION OF FINDINGS

The American Professional Society on the Abuse of Children (APSAC) formed a committee of leading pediatricians in the United States to standardize terms and definitions for the examination of sexually abused children. See **Appendix M** for the APSAC Glossary of Terms and Interpretation of Findings for Child Sexual Abuse Evidentiary Examinations. See **Appendix N** for a Labeled Diagram of Genital Structures. Training on identifying genital structures and the interpretation of findings is provided by the California Medical Training Center. See **Appendix B**.

C. EXAMINATION POSITIONS AND METHODS

Multi-method examination techniques are recommended for evaluations of children. See **Appendix O** for Illustrations of Examination Methods. Contact the California Medical Training Center for training on these methods. See **Appendix B.**

Examination Positions:

Knee chest:	**Prone:** child rests on knees with upper chest on the examination table in a lordotic (swayback) posture. **Supine:** child rests on back with flexed knees brought to chest.
Lateral recumbent:	Child is lying on side with hips and knees flexed.

Examination Methods:

Separation:	Labia majora are gently separated in a lateral and downward direction exposing the structures within the vestibule.
Traction:	Labia majora are grasped between the thumbs and index fingers and gently pulled toward the examiner.
Saline/water:	Used to float/separate the hymenal tissue that may be rolled or overlapping upon itself.
Moistened swab:	Used to reposition hymenal tissue. **Always use a moistened swab to reduce discomfort.**
Toluidine blue dye:	Used to enhance the appearance of recent microscopic abrasions.

CHAPTER XV

STANDARD FORMS FOR DOCUMENTATION OF FINDINGS

- $ OCJP 923 Forensic Medical Report:
  Acute (<72 hours) Adult/Adolescent Sexual Assault Examination

- $ OCJP 925 Forensic Medical Report:
  Non-acute (>72 hours) Child/Adolescent Sexual Abuse Examination

- • OCJP 930 Forensic Medical Report:
  Acute (<72 hours) Child/Adolescent Sexual Abuse Examination

- $ OCJP 950 Forensic Medical Report:
  Sexual Assault Suspect Examination

Suggested Use of the Standard State Forms: Follow local policy.

OCJP 923	• History of **acute sexual assault** (<72 hours) • Examination of adults (age 18 and over) and adolescents (ages 12-17)
OCJP 925	• History of **non-acute sexual abuse** (>72 hours) • Examination of children and adolescents under 18
OCJP 930	• History of **acute sexual assault or abuse** (<72 hours) • Examination of children under age 12
OCJP 930	• History of **chronic sexual abuse (incest) and recent incident** (<72 hours) • Examination of children and adolescents under age 18
OCJP 950	• Examination of person(s) suspected of sexual assault or child sexual abuse

CHAPTER XVI

ADULT AND ADOLESCENT FEMALE PATIENTS

Psychological Reactions

Sexual assaults happen in many different circumstances. The assailant may be a stranger, a date, an acquaintance, or a family member. The victim may be a child, a teenager, or an adult. Force, threats of force, weapons, threats of harm to a third person such as a child, psychological duress, intimidation, trickery, and administering incapacitating drugs are methods employed by perpetrators. Various sexual acts may be attempted or completed. Physical injuries may or may not be sustained. Most sexual assault survivors sustain significant psychological trauma regardless of:

- $ The relationship between assailant and victim;
- $ Drug or alcohol use prior to assault;
- $ The method of attack;
- $ The presence or absence of physical injuries; or
- $ Whether the assault is attempted or completed.

The psychological trauma experienced by survivors of rape and other forms of sexual assault are well documented. In the 1970's, Burgess & Holmstrom (1974) described the Rape Trauma Syndrome. Subsequent research has demonstrated that most sexual assault victims suffer from symptoms of Acute Stress Disorder and/or Post-traumatic Stress Disorder, as well as related symptomatology (Burge, 1988; Foa, 1994; DSM IV, 1994; Kilpatrick, Resick, & Veronen, 1981; Kramer & Green, 1991). Some of these symptoms are evident in the immediate aftermath of a sexual assault when survivors are seen in medical care settings. The interventions and approach used by forensic medical examiners and other caregivers should be guided by an understanding of the trauma the survivor has sustained, as well as knowledge about common psychological responses to this trauma.

A. NATURE OF THE TRAUMA

During a sexual assault, victims are exposed to a traumatic event, which may involve threat or fear of death, possible serious injury, a threat to the victim's physical integrity, or the safety of a significant other. Most victims respond to this type of trauma with feelings of intense fear, helplessness, or horror. These traumatic experiences may produce acute and/or longer-term stress disorder symptoms.

B. ACUTE POST-TRAUMATIC STRESS SYMPTOMS

The psychological reactions or Acute Stress Disorder symptoms that may be observed in survivors immediately following a sexual assault include the following:

- $ Dissociative symptoms such as numbness, detachment, depersonalization, or derealization; reduced awareness of surroundings (appears to be "in a daze");

- $ emotional unresponsiveness (flat affect); dissociative amnesia (inability to recall an important aspect of the trauma); and outward calm and collectedness;
- $ Preoccupation with the assault and persistent re-experiencing of the trauma (e.g., flashbacks, intrusive thoughts, images, dreams) or distress on exposure to reminders of the trauma (questions by law enforcement and medical personnel);
- $ Marked avoidance of stimuli that arouse recollections of the trauma (e.g., reluctance to participate in interviews with law enforcement and medical personnel); and
- $ Symptoms of anxiety, such as difficulty sleeping, irritability, problems with concentration, hypervigilance and exaggerated startle response.

The diagnosis of Acute Stress Disorder is made if these symptoms last for at least two days and for as long as four weeks, and if they occur within four weeks of the traumatic event. During this time, the survivor may experience significant distress and disruption in social, occupational, and other areas of functioning, including family relationships. Many survivors find it difficult to perform their usual activities. In addition, the survivor may be unable to mobilize to pursue needed assistance. The persistence of symptoms may indicate a diagnosis of Post-traumatic Stress Disorder.

Other psychological reactions commonly expressed by survivors in the immediate aftermath of a sexual assault include:

- $ Shock and disbelief;
- $ Hysteria;
- $ Confusion and non-sequential recollection of events;
- $ Fears about personal safety;
- $ Concerns about the consequences of reporting the assault and the reactions of others; and
- $ Adolescents: withholding information due to fear of legal, school, peer, and family consequences.

C. LONG TERM POST-TRAUMATIC STRESS SYMPTOMS

The diagnosis of Post-traumatic Stress Disorder (American Psychiatric Association, 1994) is made if specific symptoms last for more than a month and cause significant distress or disruption in the survivor's functioning.

Post-traumatic Stress Disorder symptoms include:

- $ Persistent re-experiencing of the trauma (recurrent, intrusive thoughts and distressing dreams; acting or feeling as if the sexual assault is happening again; extreme distress when exposed to something that resembles or is symbolic of the traumatic event);
- $ Persistent avoidance of people or situations associated with the trauma;
- $ Numbing or reduced responsiveness, including diminished interest or participation in significant activities, inability to recall an important aspect of the

trauma, feeling detached or estranged from others, restricted range of affect, and/or sense of a foreshortened future; and

- $ Persistent symptoms of anxiety or increased arousal, such as sleep disturbances, irritability, mood swings, difficulty with concentration, hypervigilance, and exaggerated startle response.

Additional symptoms that are commonly experienced by sexual assault survivors include:

- $ Depression;
- $ Self-blame, guilt, shame, humiliation, loss of personal dignity;
- $ Anger;
- $ Sexual dysfunction;
- $ Somatic complaints;
- $ Loss of self-confidence;
- $ Devaluation in regard to personal identity and self-esteem;
- $ Inability to concentrate and difficulty attending to tasks at hand;
- $ Changes in survivor's assumptions about themselves, others and the world; and
- $ Adolescents: Cutting school, outbursts of anger or rage, sexual promiscuity, beginning or increased drug/alcohol use, exaggerated adult behavior, high frequency of suicide attempts, and persistent anger.

D. PROVIDE A SUPPORTIVE APPROACH

There are individual differences in the duration and intensity of these psychological reactions. Many factors affect individual responses including cultural differences, life-stage and adolescent development issues, mental or physical disabilities, and previous victimization experiences. These factors may intensify the psychological trauma experienced by the patient.

Adolescents and college students are at risk for the secondary adversity of seeing the assailant at school or in their neighborhoods on a regular basis. The elderly are at risk for subsequent declining health. Developmentally disabled, hearing impaired, other handicapped individuals, as well as persons in institutionalized settings such as group homes, nursing homes, and long-term care facilities are especially vulnerable to sexual victimization and require sensitive treatment.

Crisis theory provides a framework for designing effective interventions for survivors in the immediate aftermath of a sexual assault. Crisis intervention focuses on helping survivors express feelings and concerns related to the assault, as well as on mobilizing coping strategies for dealing with its aftermath. The following guidelines (Abarbanel, 1990) structure a therapeutic approach to survivors in medical care and forensic settings:

- $ Be nonjudgmental and supportive;
- $ Foster feelings of safety and trust;
- $ Acknowledge the survivor's experience;

- $ Elicit and respond to the survivor's needs and concerns;
- $ Explain your role and purpose as a caregiver;
- $ Restore feelings of control by explaining what you wish to do and why before you do it;
- $ Give survivors information about their rights and options;
- $ Allow survivors to make decisions about their care;
- $ Provide anticipatory guidance to help prepare the survivor for the aftermath by offering information about common psychosocial reactions to sexual assault;
- $ Discuss "blame-the-victim" reactions because the survivor, family, friends, and others often seek to attribute the assault to perceptions of causal or precipitative behavior on the part of the survivor instead of to the assailant;
- $ Identify resources and coping strategies that will enable the survivor to deal with the medical, legal, and psychological impacts of the assault;
- $ Provide referrals to appropriate agencies such as rape crisis centers; and
- $ Provide important information in brochures or hand-outs because a traumatized person may have difficulty with concentration and recall.
- $ See **Appendix E** for a directory of rape crisis centers.

CHAPTER XVII

PEDIATRIC PATIENTS

Psychological Reactions and Behavioral Indicators

Child sexual abuse encompasses a broad spectrum of behavior. It may consist of many acts over a long period of time (chronic molestation) or a single incident. Victims range in age from less than one year through adolescence.

A. SEXUALLY ABUSIVE CONDUCT

- **Genital exposure**
  The adult exposes his or her genitals to the child and may ask the child to touch his or her genitals.
- **Kissing**
  The adult kisses the child in a lingering and intimate manner appropriately reserved for adults and "French kissing", the insertion of the tongue into another's mouth.
- **Fondling**
  The adult fondles the child's breasts, abdomen, genital area, inner thighs, or buttocks. The child may similarly be requested to fondle the adult.
- **Masturbation**
  The adult masturbates while the child observes; the adult observes the child masturbating; the adult and child observe each other while masturbating themselves; the adult and child masturbate each other (mutual masturbation); or the adult instructs the child to masturbate self for gratification of the adult.
- **Oral genital contact or penetration**
  Oral stimulation or manipulation of the penis (fellatio) or of the female genitalia (cunnilingus).
- **Genital or vaginal contact or penetration**
  Contact or penetration between the labia (not necessarily into the vagina) by a finger, penis, or foreign object; or, penetration of the vagina by finger, penis, or foreign object.
- **Anal contact or penetration**
  Penetration by penis between the gluteal clefts; licking of the anus with the tongue; or, penetration of the anus by finger, penis, or foreign object.
- **Intercrural or "dry intercourse"**
  The adult rubs his penis between the child's legs, against the child's anal-genital area, inner thighs, or buttocks.

- **Child pornography**

  The posing or modeling of minors involved in sexual conduct for the purpose of preparing a film, photograph, negative, slide, or a live performance. Pornography may be used as a means to instruct or prepare a child for sexual abuse. Abuser may jointly watch pornography with a child and masturbate in the child's presence.

$ **Child prostitution**

  Commercial sexual exploitation of children.

B. PERPETRATORS

Perpetrators may be immediate or extended family members, child care personnel, family friends, neighbors, acquaintances, unrelated adults in positions of authority, teachers, or strangers. They may be male, female, adults, adolescents, or older children. Young children and adolescents have also been identified as offenders. Approximately 75 to 90 percent of the perpetrators are known to the child.

C. TYPES OF CHILD SEXUAL VICTIMIZATION

1. Intrafamily child sexual abuse

The most commonly reported type of sexual abuse involves family members, stepparents, or parent surrogates. Fathers, mothers, grandparents, siblings, aunts, uncles, and cousins have been identified as perpetrators. The Child Sexual Abuse Accommodation Syndrome describes patterns of behavior exhibited by abused children (Summit, 1979):

- Keeping the sexual abuse a secret;
- Feelings of helplessness, reinforced by a sense of isolation, secrecy, and guilt;
- Entrapment and accommodation;
- Delayed, conflicted, or unconvincing disclosure; and/or
- Retraction of the complaint.

2. Child molestation by non-family members

Child care facilities, family day care, school, and after-school activity groups are other settings in which children may be vulnerable to abuse. Adults may use these positions of special trust and/or authority to abuse and exploit children.

3. Forcible child sexual assault

Two to five percent of cases involve forcible sexual assault. Most often the victim does not know the offender. The sexual acts are usually forced oral, vaginal, or anal penetration. Injuries may result from either the act or the force used to secure the submission of the victim. Typically, enticement (“come and see the ducks”) or abduction are used to separate and isolate the child from family and friends.

4. Child sexual exploitation

This term is used to describe pornography, prostitution, sex-rings, or circumstances involving organized abuse of multiple victims by multiple offenders. The perpetrators may include an association of both family and non-family members. Financial gain is the principal motivation for pornography, prostitution, and sex-rings. Abuse of multiple victims by multiple offenders, sometimes involving ritualistic practices, is a phenomenon under study.

D. METHODS EMPLOYED BY PERPETRATORS

1. Coercion

The majority of techniques used to involve children in sexual contact are coercive, rather than physical. Coercion may take the form of psychological pressure, exertion of adult authority, misrepresentation of moral standards, gifts or rewards, or force and threats. Children may cooperate because of unmet needs for love, affection, and attention; a sense of loyalty to the adult; or confusion about what to do.

2. Progression of contact

Sexual contact typically begins with “grooming behaviors” such as the giving of gifts, toys, attention, and progressive physical closeness. Touching, rubbing and fondling begin and the sexual acts may gradually proceed to masturbation, digital penetration, oral-genital contact, vaginal, or anal penetration. Oral or anal penetration may occur early in the progression because of the relative ease of penetration. Ejaculation by a male perpetrator against the child’s body, on the outer clothing, or on the bedding may occur at any time in the progression.

E. PSYCHOLOGICAL IMPACT

The most common psychological reactions to sexual abuse are listed below. The first five may occur regardless of the identity and relationship of the perpetrator to the victim. The remaining reactions are more characteristic of children sexually abused over time by a family member.

- Dissociation;
- Fear/anxiety;
- Guilt/shame;
- Depression;
- Repressed anger/hostility;
- Low self-esteem and poor social skills;
- Inability to trust, if victimized by a known or trusted person;
- Blurred boundaries and role confusion;
- Pseudomaturity coupled with failure to accomplish developmental tasks; and/or
- Developmental delay.

Cultural issues and previous victimization may intensify the psychological reaction experienced by the patient. Developmentally disabled, hearing-impaired, and other

handicapped individuals are especially at risk for sexual victimization and require particularly sensitive treatment.

F. CRISIS PERIODS

The medical examination may arouse feelings of loss of control or cause the patient to re-experience a sense of abuse and accompanying shame. The following events can also create or intensify a crisis reaction in the child victim:

- Disclosure of recent or past incidents;
- Removal from the home;
- Court appearances and sentencing;
- Confronting the perpetrator;
- Parental rejection;
- Visitation with the alleged perpetrator;
- Beginning or change in the level of visitation with the alleged perpetrator;
- Change from supervised to unsupervised visits with the alleged perpetrator; and/or
- Discovery that a sibling is also a victim.

G. INDICATORS OF CHILD SEXUAL ABUSE

Sexual abuse of a child may surface through a broad range of physical, behavioral, and social symptoms. Some of these indicators, taken separately, may not be symptomatic of sexual abuse. They are listed below as a guide, and should be examined in the context of other behavior(s) or situational factors.

1. Disclosure

The single most important indicator is disclosure to a friend, classmate, teacher, friend's mother, or other trusted adult. Twenty-five percent of disclosures are told to friends who tell their mothers.

2. Process of disclosure

Delay in disclosure by children is common. Partial and unfolding disclosures are also common. Rarely will a child sit down to tell you the "whole story". Disclosures may be direct or indirect, e.g., "I know someone". The disclosure process includes denial, tentative disclosure, active disclosure, and a possible recantation with later reaffirmation. Young children rarely describe explicit sexual activity unless they have experienced or witnessed it.

3. Physical signs and symptoms

- Presence of semen;
- Sexually transmitted diseases/organisms;
- Genital discharge or infection;
- Anal or genital pain, itching, swelling, bruising, bleeding, lacerations, or abrasions, especially if unexplained or inconsistent;
- Pain on urination/defecation;
- Difficulty in walking or sitting due to genital or anal pain;

- Stomachaches, headaches, or other psychosomatic symptoms; and
- Amenorrhea secondary to pregnancy.

4. **Sexual behaviors**
   - Detailed and age-inappropriate understanding of sexual behavior (especially by younger children);
   - Inappropriate, unusual, or aggressive sexual behavior with peers or toys;
   - Compulsive masturbation;
   - Excessive curiosity about sexual matters or genitalia (self and others);
   - Unusually seductive behavior with classmates, teachers, and other adults;
   - Prostitution or promiscuity; and/or
   - Excessive concern about homosexuality, especially with boys.
5. **Non-specific behavioral indicators in younger children that may indicate sexual abuse**
   - Enuresis;
   - Fecal soiling;
   - Eating disturbances (overeating, undereating);
   - Fears, phobias, overly compulsive behavior;
   - School problems or significant change in school performance (attitudes and grades);
   - Age-inappropriate behavior (pseudomaturity or regressive behavior such as bed-wetting or thumb sucking);
   - Inability to concentrate; and/or
   - Sleep disturbances, e.g., nightmares, fear of falling asleep, fretful sleep pattern, sleeping long hours.
6. **Non-specific behavioral indicators in older children and adolescents that may indicate sexual abuse**
   - Withdrawal;
   - Clinical depression;
   - Overly compliant behavior;
   - Poor hygiene;
   - Poor peer relations and social skills, inability to make friends;
   - Acting out, runaway, aggressive, or delinquent behavior;
   - Alcohol or drug abuse;
   - School problems, frequent absences, sudden drop in school performance;
   - Fear of home life demonstrated by arriving at school early or leaving late;
   - Refusal to dress for physical education;
   - Non-participation in sports and social activities;
   - Fear of showers/rest rooms;
   - Suddenly fearful of other things (going outside, participating in familiar activities);
   - Extraordinary fear of males;

- Self-consciousness of body beyond that expected for age;
- Sudden acquisition of money, new clothes, or gifts with no reasonable explanation;
- Suicide attempt and/or self-destructive behavior;
- Crying without provocation;
- Fire setting; and/or
- Sleeping during the day or unusual sleep patterns.

CHAPTER XVIII

ADULT AND ADOLESCENT MALE PATIENTS

Psychological Reactions

Male survivors are reluctant to disclose sexual assault for several reasons:

$ Societal beliefs that a man should be able to defend himself, especially against a sexual assault;

$ Fear that his "manhood" has been lost or that his sexual orientation may become suspect or changed as a result of the assault;

$ Men are taught to be in control of their feelings and fear that disclosure will release overwhelming emotions;

$ Fear that no one will understand; and

$ Fear that seeking help or that the assistance given will make them feel weak or vulnerable.

A. NATURE OF THE TRAUMA

During a sexual assault, victims are exposed to a traumatic event which may involve a threat or fear of death, possible serious injury, or a threat to the victim's physical integrity. The level of physical brutality inflicted upon males appears to be greater than for females. A greater likelihood of multiple perpetrators also exists for male than female victims. Male victims are more likely to show a highly "controlled" style of reaction after a sexual assault. This is likely to mask significant hidden psychological trauma. These traumatic experiences may produce acute and/or longer-term stress disorder symptoms.

B. ACUTE POST-TRAUMATIC STRESS SYMPTOMS

The Acute Stress Disorder symptoms (American Psychiatric Association, 1994) that may be observed in survivors immediately following a sexual assault include the following:

$ Dissociative symptoms such as numbness, detachment, depersonalization, or derealization; reduced awareness of surroundings (appears to be "in a daze"); emotional unresponsiveness (flat affect); dissociative amnesia (inability to recall an important aspect of the trauma); and outward calm and collectedness;

$ Preoccupation with the assault and persistent re-experiencing of the trauma (e.g., flashbacks, intrusive thoughts, images, dreams) or distress on exposure to reminders of the trauma (questions by law enforcement and medical personnel);

$ Marked avoidance of stimuli that arouse recollections of the trauma (e.g., reluctance to participate in interviews with law enforcement and medical personnel); and

- $ Symptoms of anxiety, such as difficulty sleeping, irritability, problems with concentration, hypervigilance, and exaggerated startle response.

The diagnosis of Acute Stress Disorder is made if these symptoms last for at least two days and for as long as four weeks, and if they occur within four weeks of the traumatic event. During this time, the survivor may experience significant distress and disruption in social, occupational, and other areas of functioning, including family relationships. Many survivors find it difficult to perform their usual activities. In addition, the survivor may be unable to mobilize to pursue needed assistance. The persistence of symptoms may indicate a diagnosis of Post-traumatic Stress Disorder.

Other psychological reactions commonly expressed by survivors in the immediate aftermath of a sexual assault include:

- $ Shock and disbelief;
- $ Confusion and non-sequential recollection of events;
- $ A marked "controlled" style due to gender expectation that it is unmanly to express emotion, even in the face of significant physical and emotional trauma;
- $ Being sullen and withdrawn;
- $ Having fears and concerns about personal safety and adequacy;
- $ Concerns about the consequences of reporting the assault and the reactions of others; and
- $ Adolescents: withholding information due to fear of legal, school, peer, and family consequences.

C. LONG TERM POST-TRAUMATIC STRESS SYMPTOMS

The diagnosis of Post-traumatic Stress Disorder (American Psychiatric Association, 1994) is made if specific symptoms last for more than a month and cause significant distress or disruption in the survivor's functioning.

Post-traumatic Stress Disorder symptoms include:

- $ Persistent re-experiencing of the trauma (recurrent, intrusive thoughts, and distressing dreams; acting or feeling as if the sexual assault is happening again; extreme distress when exposed to something that resembles or is symbolic of the traumatic event);
- $ Persistent avoidance of people, activities, or situations associated with the trauma;
- $ Numbing or reduced responsiveness, including diminished interest or participation in significant activities, inability to recall an important aspect of the trauma, feeling detached or estranged from others, restricted range of affect, and/or sense of a foreshortened future; and
- $ Persistent symptoms of anxiety or increased arousal, such as sleep disturbances, irritability, mood swings, difficulty with concentration, hypervigilance, and an exaggerated startle response.

Additional symptoms that are commonly experienced by male sexual assault survivors include:

- $ Concerns about sexuality and masculinity, e.g., "loss of manhood";
- $ Depression;
- $ Self-blame, guilt, shame, humiliation, loss of personal dignity;
- $ Anger;
- $ Sexual dysfunction and/or negative sexual attitudes;
- $ Somatic complaints;
- $ Devaluation in regard to personal identity and self-esteem;
- $ Inability to concentrate and difficulty attending to tasks at hand;
- $ Intensified aggressiveness;
- $ Changes in survivor's assumptions about themselves, others, and the world; and
- $ Adolescents: Cutting school, outbursts of anger or rage, sexual promiscuity, beginning or increased drug/alcohol use, exaggerated adult behavior, high frequency of suicide attempts, and persistent anger.

D. PROVIDE A SUPPORTIVE APPROACH

There are individual differences in the duration and intensity of these psychological reactions. Many factors affect individual responses including cultural differences, life-stage and adolescent developmental issues, mental or physical disabilities, and previous victimization experiences. These factors may intensify the psychological trauma experienced by the patient. Adolescents and college students are at risk for the secondary adversity of seeing their assailant at school or in their neighborhoods on a regular basis.

In general, men are socialized to be powerful, to win, to be "number one", and to be in charge. A male who is sexually assaulted not only suffers a defeat "in combat", but he may perceive that he has forfeited his sexual role. He has been "used as a woman" and has lost his "manhood". In addition to men being socialized to "fight their own battles", seeking assistance in the form of counseling may be yet another indication of personal defeat and disgrace. To ask for help can be tantamount to an admission of helplessness or weakness.

Crisis theory provides a framework for designing effective interventions for survivors in the immediate aftermath of a sexual assault. Crisis intervention focuses on helping survivors express feelings and concerns related to the assault, as well as on mobilizing coping strategies for dealing with its aftermath. The following guidelines (Abarbanel, 1990) structure a therapeutic approach to survivors in medical care and forensic settings:

- $ Be nonjudgmental and supportive;
- $ Foster feelings of safety and trust;
- $ Acknowledge the survivor's experience;
- $ Elicit and respond to the survivor's needs and concerns;

- $ Explain your role and purpose as a caregiver;
- $ Restore feelings of control by explaining what you wish to do and why before you do it;
- $ Give survivors information about their rights and options;
- $ Allow survivors to make decisions about their care;
- $ Provide anticipatory guidance to help prepare the survivor for the aftermath by offering information about common psychosocial reactions to sexual assault;
- $ Discuss "blame-the-victim" reactions because the survivor, family, friends, and others often seek to attribute the assault to perceptions of causal or precipitative behavior on the part of the survivor instead of to the assailant;
- $ Identify resources and coping strategies that will enable the survivor to deal with the medical, legal, and psychological impacts of the assault;
- $ Provide referrals to appropriate agencies such as rape crisis centers; and
- $ Provide important information in brochures or handouts because a traumatized person may have difficulty with concentration and recall.
- $ See **Appendix E** for a directory of rape crisis centers.

CHAPTER XIX

INTERVIEWING ADULTS, ADOLESCENTS, AND CHILDREN

A. GENERAL APPROACH

The goals of the health practitioner are to obtain a good history in order to perform a thorough examination and to begin the healing process through warm, nonjudgmental communication. To help achieve these outcomes, keep in mind that complete interpersonal communication has a beginning, a middle, and a closing.

Beginning

1. **Introduce yourself to the patient**
   Explain how you are associated with the patient's care. For example, explain that you are a nurse and that you work in the hospital's special program for sexual assault.

2. **Explain your role and purpose**
   Describe your role and responsibilities, how you are going to proceed, and what you are going to do at all times.

3. **Acknowledge the experience**
   Communicate your knowledge and understanding that a significant incident has occurred, that the patient is experiencing feelings about it, and the prospect of being medically examined. For example, you might say, "I know you have been through a lot and you are probably having a lot of feelings about what happened."

4. **Show awareness of possible feelings**
   Always remember that your patient does not know what to expect. The patient may be apprehensive, defensive, or anxious about being at the hospital. Your role will be to convey an awareness of these possible feelings and an openness to whatever your patient may present. Your professional ease and patience will provide the patient with the security necessary for the establishment of rapport, e.g. "we will do the best we can to make you feel comfortable and to take care of you."

5. **Express empathy**
   Empathy is the ability of the health practitioner to intuitively understand and respond to the patient's feelings and experience. The accuracy of your perceptions will be based on your awareness of the patient's affect, your understanding of what has happened to the patient, and the possible range of reactions.

6. **Maintain a professional attitude**
   Avoid making "gut level" judgments about a patient's truthfulness or credibility. All the facts are never apparent at the time of the exam, and may never be.

Personal questions, innuendo, and body language can have an adverse impact upon an already fragile patient.

7. **Focus on the patient's verbal and non-verbal message**
   Maintain your focus on identifying the patient's message and making a confirming, empathetic statement recognizing both the verbal and non-verbal content of the account. Respond to the content of the message, whether it is verbal or non-verbal (body language). In the case of a sexual assault, the main issues are fear and anxiety about safety, about the medical examination, and concerns about the reactions of others to them.

   Always keep in mind that no two patients are the same. Health care practitioners must be open, flexible, and resourceful to respond to the needs of each individual, with an honest respect for their uniqueness. Some patients may be inexpressive, numb, or feel unable to identify the feelings attached to the experience at the moment. Others may be flooded with many emotions, unable to sort out their feelings. Shutting down is a way of maintaining self-control. Creating a warm, calm atmosphere helps reduce anxiety, and begins the self-restoration process.

Middle

8. **Explain why you need a detailed history**
   Simple explanations reduce anxiety and begin to help the patient regain a sense of control. Complex, lengthy explanations require concentration and are likely to be misunderstood or forgotten. Begin by asking the patient to tell you what happened and explain that you may need to ask some follow-up questions to clarify information. Provide reassurance that some questions may feel embarrassing but that the answers will help you to perform a good examination. Support is also conveyed through nonverbal behavior. Be patient and give the patient time to respond to your questions. Listen attentively and maintain eye contact.

9. **Validate feelings expressed during the history taking and examination**
   Most patients are relieved to know that the feelings they are experiencing are normal, common reactions to sexual assault or abuse. The common reactions of shame, fear, guilt, and anxiety are often very distressing to the patient because of their nature and intensity. The patient can better manage these reactions if the health practitioner recognizes and understands them. You might say, "I can see why you feel frightened." Some patients are unable or unwilling to articulate their emotional reactions. The health practitioner can help them by suggesting that they may have these feelings, for example, "I realize you may feel afraid right now...or...embarrassed right now." Acknowledge how difficult it can be to talk about it.

10. **Respond to patient's statements of self-blame and fear**
    In response to a self-blame statement, such as, "Maybe I should have fought harder"; you might respond by reflecting back, "It sounds like you are feeling responsible for what happened." Clarify that the patient was not at fault - that she was, in fact, a victim. As the patient begins to express concerns, it is

important that you not give false or unrealistic reassurances. Although you may want to relieve the patient's stress and make her feel better, false reassurances cut off the expression of feelings, contribute to a sense of distrust, and interfere with problem solving. For example, if the patient says she is afraid because the perpetrator has not been caught, it is false reassurance to tell her that everything will be all right and she will feel better soon. Assist her instead by helping her talk about steps she can take to feel safer.

11. **Explain procedures before you begin each step.**
    Use simple easy to understand terminology. Explanations provide reassurance and restore a sense of control to the patient.

12. **Provide reassurance about their physical health after the exam is completed.**
    Patients have fears about the presence and significance of injuries. Discuss your findings to the degree it is appropriate at the time and make reassuring statements.

13. **Explain the issues pertaining to the possibility of pregnancy and sexually transmitted disease and facilitate decision-making.**
    The possibility of pregnancy and sexually transmitted disease are major concerns. Discuss the possibilities and treatment options.

Closing

14. **Prepare the patient for future reactions.**
    The closing steps for the initial interview are directed toward preparing the patient for the period following hospital care. Discharge planning includes anticipatory guidance. It gives the patient some feelings of control over the situation and provides her with a framework for understanding the experience.
    - $ Repeat or summarize previous steps and information.
    - $ Acknowledge again the traumatic or frightening nature of sexual assault.
    - $ Prepare the patient for the common reactions and feelings most patients experience.
    - $ Explain that these reactions are normal and most patients experience them to some degree.
    - $ Acknowledge that it probably will take a while for the patient to feel like herself again.

15. **Prepare the patient to leave the hospital**
    Before the patient leaves the hospital emergency department, make sure that the patient has written discharge instructions, a plan for follow-up assessment and treatment, a safe destination, companionship, and transportation.

16. **If a rape crisis center advocate was not able to be present at the time of the exam, make a referral to the local rape crisis center.**

B. SPECIAL CONSIDERATIONS FOR INTERVIEWING CHILDREN

Feelings of children
Several factors influence the experience of talking to children about what happened to them: • It may feel traumatic or embarrassing for children to describe what happened to them; • Children may feel responsible for the abuse; and, • Abuse is stressful and this may influence how children remember and describe what happened to them.

Linguistic capabilities of children
• Children may not understand the vocabulary used by the interviewer. Use developmentally appropriate questions.
• Children may not understand questions if they are worded in a complex manner such as compound sentences or double negatives.
• Use simply worded questions, e.g. "What happened to you" or "Tell me what happened."

1. **Avoid multiple, lengthy interviews**
   - $ Establish agreements with local law enforcement personnel, prosecutors, and child protective service workers to coordinate the number of interviews needed.
   - $ If the child is reluctant to volunteer information, consult with child protective services and law enforcement personnel to develop an interview plan.
2. **Interview children alone**
   Children are often reluctant to talk about sexual matters in the presence of parents, especially if a parent is non-protective, in denial, colludes with the perpetrator, or is the perpetrator.
3. **Avoid having the child present during the adult's description of what occurred**
   The child may experience shame which further deepens the experience, react to the shame by minimizing their own account; or, be influenced by the adult's description of events.
4. **Avoid encounters, interactions, or confrontations between the child and alleged perpetrator**
   Encountering the alleged perpetrator may frighten the child and cause her to deny or minimize the description of events.
5. **Interview setting**
   - $ Interview children in a warm, friendly setting oriented to their needs to enable them to feel comfortable and to experience some degree of control returned to them; and
   - $ Provide privacy with no or minimal interruptions.

6. **Qualifications of the interviewer**
   Medical personnel should be knowledgeable about the differences between supportive, sensitive questioning and asking inappropriate, leading or suggestive questions. Consultation on this issue with local law enforcement agencies or the county prosecutor's office is recommended. Multi-disciplinary interview teams exist in many counties with specially trained interviewers who can provide training.

7. **Express a warm, friendly, supportive style**
   - $ Convey a relaxed, unhurried attitude and express concern about the child's well being. Children easily recognize adults who are anxious, uncomfortable, hurried, or ill at ease and are affected accordingly.
   - $ Avoid being judgmental or biased about information supplied by the child or projecting your own feelings or perceptions about the situation onto the child. Do not presuppose guilt or anger as neither may be present. Do not presuppose the child found the sexual contact unpleasant.

8. **Conducting the interview**
   - $ Take time to establish rapport. Begin with a discussion of common, non-sexual topics to enable the child to become comfortable with the situation and to determine the child's general level of functioning.
   - $ Avoid focusing on the topic of abuse prior to establishing rapport.
   - $ Use language appropriate to the developmental level and background of the child.
   - $ Determine the child's understanding of, and terminology for, body parts and functions. Be prepared to use the child's own terminology.
   - $ Use toys, stuffed animals, anatomical dolls, pictures, or anatomical diagrams to provide a nonverbal vehicle for children to describe what happened to them. Avoid a "play" atmosphere when gathering information about sensitive events.
   - $ Begin by asking open-ended "free recall" questions such as: WHAT HAPPENED TO YOU? TELL ME WHAT HAPPENED. WHO DID THIS? WHAT DID HE DO or WHAT DID SHE DO? These types of questions are easiest for children to answer.
   - $ Avoid WHY questions or questions that require understanding abstract concepts.
   - $ Avoid inappropriate prompting, leading, or suggestive questions.
   - $ Do not dwell too heavily on the identity of the alleged perpetrator and ask questions about all parties involved.
   - $ Ask WHEN questions in terms children can understand. Children to the age of about nine years often have a poorly developed concept of time and may be inconsistent or unrealistic answering questions. Time is related to events such as birthdays, holidays, the name of their teacher at the time, or their grade in school.

9. Documentation of the medical interview

- $ Record direct quotes of the child's statements. Do not paraphrase, minimize, or characterize a child's response.
- $ Consider the use of videotaped or audio taped interviews. If videotaping the interview, be sure to clarify the purpose of the videotaping and who will see the tape. Consult with the local district attorney's office on this matter.

10. Reassurance of the child

Children need to be told they are not to blame for what happened to them. Be prepared to reassure them during or at the conclusion of the interview and examination about:

- $ The presence or absence of physical injury;
- $ Fear of consequences or punishment because of disclosure or the child's role in the incident; and
- $ Concerns about teasing at school, further assault, or potential family separation.

11. Reassurance of the parents

Be prepared to reassure the parent during or at the conclusion of the interview and examination about the:

- $ Presence or absence of physical injury; and
- $ Possible psychological consequences of the abuse for the child.

12. Follow-up psychological care

Arrangements and/or referrals should be made for crisis intervention or short-term or long-term therapy.

CHAPTER XX

SEXUAL ASSAULT SUSPECT EVIDENTIAL EXAMINATION

A. PRIOR AGREEMENTS

1. Prior agreements should be established between local law enforcement agencies and hospitals to conduct these examinations.

2. Develop local protocols to ensure coordination for performance of suspect evidential examinations.

- The law enforcement officers requesting the examination must provide authorization for the examination.
- Patient consent is not required if the suspect is in custody.
- For the patient not in custody, documentation of voluntary consent for the evidential examination is the responsibility of the officer accompanying the patient. This information should be documented in the police report.
- Consult the local district attorney's office and law enforcement agencies to develop local policy on how to handle suspects who physically resist an evidential examination.

B. GENERAL GUIDELINES

1. Demonstrate a nonjudgmental attitude

$ Suspects should be given the respect and medical treatment that any patient deserves. Medical professionals must remain objective and avoid the assumption that the suspect is guilty.

$ Information and evidence obtained from the suspect examination may help prove innocence or confirm guilt.

2. Conduct timely examinations

Examinations of suspects will yield more useful information if conducted within hours of the alleged assault. In most circumstances, a general guideline for conducting suspect exams is within 72 hours of the alleged incident. Injuries such as lacerations, bruises, and bites, however, can be observed after a longer period of time. The longevity of most evidence is dependent on activities of the suspect after the assault such as bathing, changing clothes, etc. For these reasons, 72 hours should not be viewed as a rigid cut-off. Professional judgment should be used.

3. Prevent contact between the victim and the suspect

Once the emergency room is notified by law enforcement personnel that a suspect is being brought into the emergency department, ascertain whether the victim will also be brought to the hospital. If so, arrange for appropriate rooms or times for the examinations to prevent contact between them.

4. **Take security precautions**

   When a suspect is brought to the emergency department by law enforcement officers, the person should be escorted to a private room as soon as possible. A law enforcement officer should be present with the person **at all times**.

5. **Obtain information prior to the examination**

   Obtain information about the alleged assault from the law enforcement officer prior to beginning the examination and record it on a separate worksheet. This information is necessary to direct the examiner to look for injury and evidence not readily visible. Do not record this information on the OCJP 950 Forensic Medical Report: Sexual Assault Suspect Examination.

6. **Ask the law enforcement officer questions regarding:**

   - Date and time of alleged assault;
   - Alleged acts;
   - Any potential injuries that may have been inflicted by the victim upon the assailant;
   - Location and physical surroundings of the assault; and
   - Any physical identifying information provided by the victim such as scars, tattoos, etc.

7. **Accept and record the suspect's statement, if it is volunteered.**

8. **Use the recommended forensic medical report form to document findings**

   The OCJP 950 Forensic Medical Report: Sexual Assault Suspect Examination is recommended for purposes of consistency and completeness. It is not, however, required by state law. Instructions for performing these examinations are on the form.

9. **Male and female suspect evidential examinations**

   The OCJP 950 Forensic Medical Report: Sexual Assault Suspect Examination was designed for male suspects because males are the primary perpetrators of these crimes. There are instances of adult female suspects having sexual intercourse with young male victims who are minors. Young male victims tend to delay disclosure past 72 hours and longer - typically months and years. The probability of immediate apprehension in a case of recent sexual intercourse between an adult female and a male minor is low. For this reason, it was agreed to make the OCJP 950 a form for male suspects. In the event of a female suspect apprehension within 72 hours of the incident, it is recommended that the OCJP 923 Forensic Medical Report for Acute Adult/Adolescent Examinations be used and modified as needed.

CHAPTER XXI

POSSIBILITY OF PREGNANCY

A. ASSESS THE RISK OF PREGNANCY

1. Probabilities

Discuss the probability of pregnancy with the patient given the different variables described below. Females of various ages, social, and religious backgrounds will have differing feelings regarding the treatment options most acceptable to them. Major concerns include the patient's attitude toward conception, emergency contraception, abortion, and the desire to minimize the risk of pregnancy as a result of a sexual assault.

- $ The probability of conception from a single, random, unprotected intercourse is estimated to be between two and four percent.
- $ The probability of conception from a single, unprotected, midcycle intercourse (days 11 to 18 of a 28-day cycle) is at least 10 percent, and may be as high as 30 percent if the exposure was on the estimated day of ovulation.
- $ These numbers are based upon statistical probabilities. Any female with reproductive capacity can potentially become pregnant from any single exposure.

2. Pregnancy risk for adolescents

Pregnancy risk should be considered for all females, Tanner Stage 3 and above, irrespective of menarche.

3. Other variables

Determination of the probability of conception is also dependent on other variables, e.g., the use of contraceptives, regularity of menstrual cycle**,** fertility of the patient and the alleged perpetrator, time in the cycle of the exposure, and whether the perpetrator ejaculated intravaginally.

B. BASELINE PREGNANCY TEST

If there is any possibility that the patient has reproductive capability, a baseline pregnancy test should be performed at the time of the sexual assault examination to determine pregnancy status.

Baseline Pregnancy Testing:

$ Use a sensitive beta-HCG pregnancy test. Most commercially available urine pregnancy tests are very specific and sensitive to about 50 milli-international units/ml and will detect a pregnancy 8-9 days after conception (before a menstrual period is missed).
$ If this test is positive, emergency contraception is contraindicated and decisions about other medication (e.g. STD prophylaxis) must be made in consideration of the pregnancy.
$ If the test is negative -- and the patient has had unprotected intercourse within the last 10 days and would continue that pregnancy if conception has occurred -- then she must be considered to be pregnant and emergency contraception is contraindicated.

C. ALTERNATIVE TREATMENTS

1. Discuss Treatment Options

- $ Two Immediate Treatment Options:
  - $ Postcoital hormonal therapy; or
  - $ Postcoital insertion of a copper-containing intrauterine device (IUD).
- $ No Immediate Treatment Decision

  If the patient decides to forego immediate treatment, she must wait a minimum of ten days to determine if conception did occur. Discuss possible outcomes and options:
  - $ No pregnancy;
  - $ Menstrual extraction performed within two weeks of conception;
  - $ Therapeutic abortion; or
  - $ Continue pregnancy and refer patient to a family planning agency, adoption agency, or county department of social services.

2. Postcoital Combination Therapy

- $ Emergency Contraceptive Pills (ECPs) are ordinary birth control pills containing the hormones estrogen and progestin. The FDA has recently approved seven brands of combined oral contraceptives for use as emergency contraception.
- $ The efficacy of these methods has been well established in clinical trials. The risk of unwanted pregnancy can be significantly reduced using ECPs.
- $ ECPs are extremely safe. The only absolute contraindication is pre-existing pregnancy because ECPs will not work if the patient is already pregnant. ECPs will not cause an abortion. Because these hormone doses are so small and the treatment duration so brief, the standard absolute contraindications to oral contraceptives do not apply.

Relative contraindications to ECPs include:

$ Active migraine with neurologic symptoms;
$ History of stroke (CVA);
$ History of pulmonary embolus (PE); or
$ History of deep vein thrombophlebitis (DVT).
$ **Note:** If any of these conditions are present, it is safer to use a "Progestin Only" hormone method or insert a Copper-T IUD.

Dosage Schedule - all hormonal methods require two doses:

$ The first dose is given at the time of the examination and must be given within 72 hours of the exposure. Effectiveness decreases if the exposure-treatment initiation interval is over 72 hours.
$ The second (and final) dose is given 12 hours later.

Regimens for emergency contraception using combination (estrogen/progesterone) oral contraceptives:

Brand	Pills per dose	Ethynyl estradiol per dose (mg)	Levonorgestrel per dose (mg)
Ovral®	2 white pills	100	0.50
Alesse®	5 pink pills	100	0.50
Nordette®	4 light-orange pills	120	0.60
Levlen®	4 light-orange pills	120	0.60
Lo/Ovral®	4 white pills	120	0.60
Triphasil®	4 yellow pills	120	0.50
Tri-levlen®	4 yellow pills	120	0.50

$ **Side Effects**

$ ECPs are generally well tolerated. Some patients, particularly adolescents, will experience mild nausea and may vomit. To reduce the risk of vomiting, the pills may be taken with food.

Options to prevent vomiting:

Source	Medicine	Brand	Dosage	Notes
Over the counter antiemetics	Meclizine Dimenhydrinate	Antivert® Dramamine®	25mg 25mg	30-60 minutes prior to the dose
Rectal suppository (by prescription)	Trimethobenzamide Promethazine	Tigan® Phenergan®	200mg 25mg	
Note: If vomiting occurs within two hours of taking a dose of the ECPs, the ECP dose should be repeated.				

$ **Follow-up**

- $ The menses following ECP treatment may be heavier or lighter than usual and may not occur at the expected time.
- $ If no bleeding has occurred within three weeks, the patient must be evaluated and a repeat pregnancy test performed.
- $ The patient must be advised not to have unprotected intercourse until after the menses has occurred, or the repeat pregnancy test is negative.

3. Progestin only emergency contraception

- $ This method is similar to combination ECP therapy but uses only the progestin Levonorgestrel. Levonorgestrel alone is now FDA approved for emergency contraception.
- $ It may be a good alternative for patients needing emergency contraception but who have relative contraindications to combined oral contraceptives.
- $ As with the combination hormone method, the progestin only pills are started within 72 hours of exposure and given in two doses 12 hours apart.
- $ The recommended regimen uses:

  Ovrette® (Levonorgestrel)
  Each dose: 20 yellow pills (total 0.75mg/dose)

  OR

  Plan B® (Levonorgestrel)
  Each dose: one pill (0.75mg/dose)

- $ There is less nausea and vomiting with this method.
- $ Follow-up is the same for the combination hormone method.

4. **Copper-T intrauterine device**
   - $ This method is not officially approved by the FDA for emergency contraception but has been well studied in clinical trials.
   - $ The method is highly effective (less than 1 % pregnancy rate).
   - $ The Copper-T will be effective if inserted within 5 days after exposure.
   - $ The contraindications, precautions, technique of insertion, complications and follow-up are the same as for an IUD used for routine contraception.
   - $ A special caution involves the insertion-related risk of pelvic inflammatory disease. Since the sexual assault victim is at greater risk for contracting a sexually transmitted disease from the assault, STD prophylaxis should be given one hour prior to insertion.

5. **Sample Discharge Instructions**

   Refer to **Appendix P** for Sample Discharge Instructions for Pregnancy and Sexually Transmitted Disease.

CHAPTER XXII

PROPHYLAXIS AGAINST SEXUALLY TRANSMITTED DISEASE

The following information has been adapted from the *1998 Guidelines for Treatment of Sexually Transmitted Diseases* by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), Atlanta, Georgia.

This protocol describes the procedures necessary to comprehensively interview and examine the sexual assault patient, document findings and collect evidence to aid in the investigation and prosecution of the crime. The protocol promotes and encourages the highest quality medical and emotional care for all patients but does not purport to mandate or restrict medical decision making. Recommendations in the protocol regarding medical evaluation and treatment issues are included only as guidelines or suggestions to assist the examiner. The ultimate responsibility for medical management of the sexual assault patient rests with the clinician and is beyond the scope of the protocol.

A. SEXUALLY TRANSMITTED DISEASE MANAGEMENT IN ADOLESCENT AND ADULT VICTIMS OF SEXUAL ASSAULT

- $ In sexually active adults and adolescents, the issues of sexually transmitted disease (STD) risk and identification after sexual assault is more important for the medical and psychological management of the patient than for forensic purposes since the infection could have been present before the assault.
- $ No firm data or consensus has been developed to determine the risk of a victim contracting an STD following a sexual assault.
- $ The most frequently diagnosed infections at the time of the sexual assault evaluation are trichomoniasis, bacterial vaginosis, chlamydia, and gonorrhea. Chlamydia and gonorrhea pose the added potential risk of ascending infection (PID or Pelvic Inflammatory Disease). Other significant STDs that are a potential complication of sexual assault include hepatitis B and C, syphilis, HIV (Human Immunodeficiency Virus), HSV (Herpes Simplex Virus), and HPV (Human Papilloma Virus).

1. Standard STD testing

- $ The CDC recommends pre-treatment cultures for *N. gonorrhoeae*, *C. Trachomatis*, and a wet mount to evaluate for evidence of bacterial vaginosis and yeast. Wet mount and culture (if available) for *T. vaginalis* should be done.
- $ This protocol does not require these tests, and leaves their use to the discretion of the clinician. For adults and sexually active adolescents, these tests do not have forensic evidential value because they only show pre-existing health conditions.

$ If the patient chooses prophylaxis, pre-treatment cultures are unnecessary.

2. Serologic STD testing

$ The CDC recommends collection of a serum sample from the patient at the time of the examination for evaluation of hepatitis B, syphilis, and HIV.

$ Post-exposure hepatitis B vaccinations (without HBIG) should adequately protect against infection from the hepatitis B virus. The protocol does not require hepatitis B testing but recommends prophylaxis. If the victim has a reliable history of complete hepatitis B vaccination, then hepatitis B prophylaxis is unnecessary.

$ Incubating syphilis transmitted at the assault should be eradicated by the medication given to pretreat against gonorrhea and chlamydia. Syphilis testing at the time of the examination may uncover an unrecognized pre-existing infection which is a personal and public health problem, but not a forensic issue. The protocol does not require syphilis serology and leaves the decision to the clinician.

$ The issues related to HIV testing, counseling, prophylaxis, and follow-up are complex and controversial. This protocol recommends HIV risk assessment for all sexual assault patients but does not require testing as part of the forensic examination process. Patients should be expeditiously referred to local resources capable of comprehensive HIV services.

$ Current California law allows alleged perpetrator testing, if requested by the victim; however, the suspect must be charged with the crime. The local county district attorney's office is responsible for handling these requests.

3. Prophylaxis

If the patient's clinical presentation suggests a pre-existing ascending STD infection, such as fever, abdominal or pelvic pain, and/or vaginal discharge, the patient should be evaluated and treated for the ascending infection. This may differ from recommended STD prophylaxis.

All patients should be strongly encouraged to accept routine preventive therapy after sexual assault. Adequate follow-up of sexual assault patients is very difficult. Prophylaxis at the time of the forensic examination is prudent and cost effective. The enabling statute for the protocol does not require the law enforcement agency to pay for STD prophylaxis. Most medical facilities, however, have opted to dispense medication for STD (and pregnancy) prophylaxis directly to the patient at the time of the exam for the patient's well-being and for public health reasons.

See chart on next page for recommended STD treatment regimen.

Recommended regimen:

• Gonorrhea	Suprax® (Cefixime) - 400mg orally single dose	OR	• Rocephin® (Ceftriaxone) - 125mg IM in single dose
		PLUS	
• Trichomoniasis	Flagyl® (Metronidazole) - 2g orally single dose		
		PLUS	
$ Chlamydia	Zithromax® (Azithromycin) - 1g orally single dose	OR	• Doxycycline - 100mg orally 2x/day for 7 days
$ Hepatitis	Hepatitis B vaccination (without HBIG)		• First dose should be given at the time of the forensic medical examination. • The patient should be referred for follow-up to complete the immunization schedule
Many alternatives are available to address such factors as patient's age, pregnancy, or drug allergies. Consult the CDC guidelines for details.			

4. CDC recommendations for approaching the risk of acquiring HIV infection from sexual assault

Although HIV-antibody seroconversion has been reported among persons whose only known risk factor was sexual assault or sexual abuse, the risk for acquiring HIV infection through sexual assault is low. The overall probability of HIV transmission from an HIV-infected person during a single act of intercourse depends on many factors. These factors may include the type of sexual intercourse (i.e., oral, vaginal, or anal); presence of oral, vaginal or anal trauma; site of exposure to ejaculate; viral load in ejaculate; and presence of STD in the patient.

In certain circumstances, the likelihood of HIV transmission also may be affected by postexposure therapy for HIV with antiretroviral agents. Postexposure therapy with zidovudine has been associated with a reduced risk for HIV infection in a study of health-care workers who had percutaneous exposures to HIV-infected blood. On the basis of these results and the biologic plausibility of the effectiveness of antiretroviral agents in preventing infection, postexposure

therapy has been recommended for health-care workers who have percutaneous exposures to HIV. However, whether these findings can be extrapolated to other HIV-exposure situations, including sexual assault, is unknown. A recommendation cannot be made, on the basis of available information, regarding the appropriateness of postexposure antiretroviral therapy after sexual exposure to HIV. In children, even less information is available on post HIV-exposure prophylaxis.

Health-care providers who consider offering postexposure therapy should take into account the likelihood of exposure to HIV, the potential benefits and risks of such therapy, and the interval between the exposure and initiation of therapy. Because timely determination of the HIV-infection status of the assailant is not possible in many sexual assaults, the health-care provider should assess the nature of the assault, any available information about HIV-risk behaviors exhibited by persons who are sexual assailants (e.g., high-risk sexual practices and injecting-drug or crack cocaine use), and the local prevalence of HIV/AIDS.

If antiretroviral postexposure prophylaxis is offered, the following information should be discussed with the patient:

- the unknown efficacy and known toxicities of antiretroviral medications;
- the critical need for frequent dosing of medications;
- the close follow-up that is necessary;
- the importance of strict compliance with the recommended therapy; and
- the necessity of immediate initiation of treatment for maximal likelihood of effectiveness.

Centers choosing to offer this prophylaxis should develop protocols for consent, treatment, and follow up.

5. Follow-up instructions and care

- Patients should be counseled about STD symptoms and the need for immediate evaluation if symptoms occur.
- Abstinence from sexual activity is recommended until STD prophylaxis is completed.
- The CDC recommends a follow-up visit two weeks after the forensic examination. At that time pregnancy and STD issues can be re-evaluated depending on the details of the case and in context with the initial management.
- Hepatitis B vaccinations should be given at current recommended intervals after the initial dose at the time of the exam.
- If the clinician has initiated syphilis and/or HIV serologic testing, follow-up sampling should be repeated at 6, 12, and 24 weeks for HIV and at 6 weeks for syphilis.

B. EVALUATION OF CHILDREN FOR SEXUALLY TRANSMITTED DISEASE

STD testing has forensic evidential value for children and non-sexually active adolescents.

- $ Perform procedures so as to minimize pain and trauma to the child.
- $ Make the decision to evaluate the child for STDs on an individual patient basis.
- $ Situations involving a high risk for STDs and a strong indication for testing include the following:
  - $ A suspected offender is known to have an STD or to be at high risk for STDs (e.g., has multiple sex partners or a history of STD);
  - $ The child has symptoms or signs of an STD or of an infection that can be sexually transmitted; and/or
  - $ The prevalence of STDs in the community is high.

1. Standard STD Testing

- $ Cultures for *N. gonorrhea* specimens collected from the pharynx and anus in both boys and girls, in the vagina in girls, and the urethra in boys. Cervical specimens are not recommended for prepubertal girls. For boys, a meatal specimen of urethral discharge is an adequate substitute for an intraurethral swab specimen when discharge is present. Only standard culture systems for the isolation of *N. gonorrhea* should be used. All presumptive isolates should be confirmed by at least two tests that involve different principles. Isolates should be preserved in case additional or repeated testing is needed.
- $ Cultures for *C. trachomatis* from specimens collected from the anus in both boys and girls and from the vagina of girls. A urethral specimen should **only** be obtained if urethral discharge is present. Pharyngeal specimens for *C. trachomatis* are not recommended for either sex because the yield is low. Only standard culture systems for the isolation of *C. trachomatis* should be used. At present, non-culture tests do not have proven sensitivity and specificity in the prepubertal child to be used reliably as forensic evidence.
- $ Wet mount of vaginal swab specimen for *T. vaginalis* infection. Obtain culture for *T. vaginalis* where available.
- $ The presence of clue cells in the wet mount or other signs, such as positive whiff test, suggests Bacterial Vaginosis (BV) in girls who have vaginal discharge. The significance of clue cells or other indicators of BV as an indicator of sexual exposure is unclear.
- $ Visual inspection of the genital and perianal areas for genital warts and ulcerative lesions. Conduct testing for herpes simplex if symptoms are present. Appropriate testing should include both HSV Culture of a lesion and IgM and IgG serology for both HSVI and HSVII. For HSV serology, specify IgM and IgG for both HSVI and HSVII.

2. Serologic STD Testing

- $ Collect a serum sample to be evaluated immediately, preserved for subsequent analysis, and used as a baseline for comparison with follow-up serologic tests.

- $ Sera should be tested immediately for antibodies to sexually transmitted agents such as *T. pallidum* (syphilis), HIV, and Hepatitis B. Hepatitis B is unnecessary in children with a reliable history of complete Hepatitis B vaccination.

3. Presumptive Treatment

The risk for a child's acquiring an STD as a result of sexual abuse has not been determined. The risk is believed to be low in most circumstances, although documentation to support this position is inadequate.

Presumptive treatment for children who have been sexually assaulted or abused is not widely recommended. However, some children, or their parents or guardians, may be concerned about the possibility of infection with an STD, even if the risk is perceived by the health care provider to be low.

If needed, the following are appropriate doses for treatment of uncomplicated STD's or STD prophylaxis. Adolescents 12 years and older may use the adult regimen.

$ Gonorrhea	Under 12 years old or weighs < 45 kg.	Ceftriaxone	$ 125mg IM single dose
$ Chlamydia	Under 8 years old or weighs < 45 kg.	Erythromycin	$ 50mg/kg/day 4x/day for 10-14 days. Maximum dose is 2g/day.
	Over 8 years old	Azithromycin Doxycycline	$ 1 Gm orally in a single dose $ 100mg orally 2x/day for 7 days
$ Trichomonas	Under 12 years old or weighs < 45 kg.	Metronidazole	$ 40mg/kg single dose or 15mg/kg/day 3x/day for 7 days. Maximum dose is 2g/day.

4. Follow-up care

Repeat tests should be conducted at the same intervals as adults.

5. Sample Discharge Instructions

Refer to **Appendix P** for Sample Discharge Instructions for Pregnancy and Sexually Transmitted Disease.

CHAPTER XXIII

FOLLOW-UP PATIENT CARE

Following the examination, time should be spent discussing with the patient any issues, which may have arisen during the course of the examination. Examiners should refer to previous sections of the protocol for information pertaining to females, males, and children to help the patient anticipate feelings, fears, or concerns.

A. SAMPLE WRITTEN INSTRUCTIONS

Follow-up instructions and referrals should be given in writing. Refer to **Appendix P** for Sample Discharge Instructions for Pregnancy and Sexually Transmitted Disease.

B. PSYCHOLOGICAL REACTIONS

- $ Discuss the possibility of psychological reactions with patients of appropriate age and their family members.
- $ Remember that adolescents (between the ages of 12-17) and adults must be given strict confidentiality protection regarding their medical and psychological care.
- $ Reassure patients and parents of child victims about the presence or absence of physical injury.
- $ All patients need to be told that they are not to blame for what happened to them.
- $ Children especially need reassurance due to fear of consequences or punishment for disclosure or the child's role in the incident.
- $ Provide referrals to a local rape crisis center, child sexual abuse treatment program, county victim/witness assistance center, mental health center, or local psychotherapist. See the appendix for directories.

C. CRIME VICTIM COMPENSATION

Discuss the availability of crime victim compensation. Refer the patient to the local victim/witness assistance center. Refer to **Appendix F** for a directory of these centers. These programs provide assistance in preparing claims for submission to the State Victim's of Crime Program. For further information, call the State Victim's of Crime Program at 1-800-777-9229.

D. MEDICAL AND FORENSIC FOLLOW-UP APPOINTMENTS

- $ Arrange follow-up appointments for injuries and medical issues as indicated.
- $ Schedule STD and pregnancy follow-up two weeks after the exam.
- $ If serologic STD testing has been initiated, arrange follow-up.
- $ Follow the recommended schedule on the next page.

Recommended Follow-up Schedule

Patients with evidence of acute trauma	
$ Schedule a short-term (1-4 days later) follow-up appointment:	$ To re-examine and document the development of visible findings, e.g., bruises; and $ To photograph areas of potential injury, e.g., tenderness on the initial exam.
$ Schedule a wellness exam and photographs (2-4 weeks later):	$ To document resolution of findings or healing of injuries.

All patients	
$ Schedule a follow-up appointment 10 days to 2 weeks after the acute examination:	$ To review lab test results with the patient, or child and family; and $ For follow-up examination for sexually transmitted disease, i.e., cultures and wet mounts.

Long term follow up care can be performed by the patient's primary medical provider:	
$ Schedule a follow-up appointment 6 weeks after the acute examination:	$ For serologic tests, i.e., syphilis, HIV, second dose of Hepatitis B vaccine.
$ Schedule a follow-up appointment 12 weeks after the acute examination:	$ For an HIV test.
$ Schedule a follow-up appointment 24 weeks after the acute examination:	$ For a third dose of Hepatitis B vaccine; and $ For a final HIV test.

Appendix A

Penal Code 13823.5-13823.11: Minimum Standards

APPENDIX A

Senate Bill No. 892

CHAPTER 812

An act to add Section 1281 to, and to repeal Sections 1493 and 1494 of, the Health and Safety Code, and to repeal and add Section 13823.5 of, and to add Sections 13823.7, 13823.9, and 13823.11 to, the Penal Code, relating to sexual assaults.

[Approved by Governor September 19, 1985. Filed with Secretary of State September 19, 1985.]

LEGISLATIVE COUNSEL'S DIGEST

SB 892, Seymour. Sexual assaults: examination and treatment.

Existing law requires the State Department of Health Services to adopt a protocol for the examination of a victim of rape or other sexual assault and guidelines for the treatment of any such victim. The protocol and the guidelines are required to be used by medical personnel in county hospitals. The department, in cooperation with the Department of Justice, also is required to adopt a standard form for recordation of medical data disclosed by examination of such a victim; the form is required to be used by physicians in a county hospital and any other general acute care hospital who examine such a victim.

Existing law also requires the advisory committee established by the Office of Criminal Justice Planning to establish standardized procedures for the collection of evidence from victims of sexual assaults and attempted sexual assaults who are treated in hospital emergency rooms.

This bill would repeal those provisions requiring the State Department of Health Services to perform the functions specified above and would require the Office of Criminal Justice Planning, with the assistance of the advisory committee, to develop a protocol and guidelines for the examination and treatment of victims of sexual assault and attempted sexual assault, including child molestation, and the collection and preservation of evidence therefrom. It also would specify certain standards for such an examination and the collection and preservation of evidence. It would require all general acute care hospitals, whether public or private, either to comply with these standards and the protocol and guidelines or to adopt a protocol referring victims of these crimes to a hospital that so complies, thus establishing a state-mandated local program as the requirement would be applicable to various local public hospitals. The bill also would require the Office of Criminal Justice Planning, in cooperation with the State Department of Health Services and the Department of Justice, to adopt a standard form for the recordation of medical data disclosed by examination of a victim of sexual assault or attempted sexual assault, including child molestation, as specified.

The bill also would make related changes.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates which do not exceed $500,000 statewide and other procedures for claims whose statewide costs exceed $500,000.

This bill would provide that no reimbursement shall be made from the State Mandates Claims Fund for costs mandated by the state pursuant to this act, but would recognize that local agencies and school districts may pursue any available remedies to seek reimbursement for these costs. It also would make an additional statement as to the lack of an appropriation reimbursing local agencies for costs.

This bill would provide that, notwithstanding Section 2231.5 of the Revenue and Taxation Code, this bill does not contain a repealer, as required by that section; therefore, the provisions of the bill would remain in effect unless and until they are amended or repealed by a later enacted bill.

The people of the State of California do enact as follows:

SECTION 1. Section 1281 is added to the Health and Safety Code, to read:

1281. All public and private general acute care hospitals either shall comply with the standards for the examination and treatment of victims of sexual assault and attempted sexual assault, including child molestation, and the collection and preservation of evidence therefrom, specified in Section 13823.11 of the Penal Code, and the protocol and guidelines therefor established pursuant to Section 13823.5 of the Penal Code, or they shall adopt a protocol for the immediate referral of these victims to a local hospital that so complies, and shall notify local law enforcement agencies, the district attorney, and local victim assistance agencies of the adoption of the referral protocol.

SEC. 2. Section 1493 of the Health and Safety Code is repealed.

SEC. 3. Section 1494 of the Health and Safety Code is repealed.

SEC. 4. Section 13823.5 of the Penal Code is repealed.

SEC. 5. Section 13823.5 is added to the Penal Code, to read:

13823.5. (a) The Office of Criminal Justice Planning, with the assistance of the advisory committee established pursuant to Section 13836, shall establish a protocol for the examination and treatment of victims of sexual assault and attempted sexual assault, including child molestation, and the collection and preservation of evidence therefrom. The protocol shall contain recommended methods for meeting the standards specified in Section 13823.11.

(b) In addition to the protocol, the office shall develop

informational guidelines, containing general reference information on evidence collection, examination of victims and psychological and medical treatment for victims of sexual assault and attempted sexual assault, including child molestation.

In developing the protocol and the informational guidelines, the office and the advisory committee shall seek the assistance and guidance of organizations assisting victims of sexual assault; nurses, physicians and surgeons, criminalists, and administrators who are familiar with emergency room procedures; victims of sexual assault; and law enforcement officials.

(c) The office, in cooperation with the State Department of Health Services and the Department of Justice, shall adopt a standard and a complete form or forms for the recording of medical and physical evidence data disclosed by a victim of sexual assault or attempted sexual assault, including child molestation.

Each physician and surgeon or other health care professional in a public or private general acute care hospital who conducts an examination for evidence of a sexual assault or attempted sexual assault, including child molestation, shall use the standard form adopted pursuant to this section, and shall make such observations and perform such tests as may be required for recording of the data required by the form. The forms shall be subject to the same principles of confidentiality applicable to other medical records.

The office shall make copies of the standard form or forms available to every public or general acute care hospital, as requested.

The standard form shall be used to satisfy the reporting requirements specified in Sections 11160 and 11161 in cases of sexual assault, and may be used in lieu of the form specified in Section 11168 for reports of child abuse.

(d) The office shall distribute copies of the protocol and the informational guidelines to every general acute care hospital, law enforcement agency, and prosecutor's office in the state.

SEC. 6. Section 13823.7 is added to the Penal Code, to read:

13823.7. The protocol adopted pursuant to Section 13823.5 for the examination and treatment of victims of sexual assault or attempted sexual assault, including child molestation, and the collection and preservation of evidence therefrom shall include provisions for all of the following:

(a) Notification of injuries and a report of suspected child sexual abuse to law enforcement authorities.

(b) Obtaining consent for the examination, for the treatment of injuries, for the collection of evidence, and for the photographing of injuries.

(c) Taking a patient history of sexual assault and other relevant medical history.

(d) Performance of the physical examination for evidence of sexual assault.

(e) Collection of physical evidence of assault.

(f) Collection of other medical specimens.

(g) Procedures for the preservation and disposition of physical evidence.

SEC. 7. Section 13823.9 is added to the Penal Code, to read:

13823.9. (a) Every public or private general acute care hospital that examines a victim of sexual assault or attempted sexual assault, including child molestation, shall comply with the standards specified in Section 13823.11 and the protocol and guidelines adopted pursuant to Section 13823.5.

(b) Each county with a population of more than 100,000 shall arrange that professional personnel trained in the examination of victims of sexual assault, including child molestation, shall be present or on call either in the county hospital which provides emergency medical services or in any general acute care hospital which has contracted with the county to provide emergency medical services. In counties with a population of 1,000,000 or more, the presence of these professional personnel shall be arranged at least one general acute care hospital for each 1,000,000 persons in the county.

(c) Each county shall designate at least one general acute care hospital to perform examinations on victims of sexual assault, including child molestation.

(d) (1) The protocol published by the Office of Criminal Justice Planning shall be used as a guide for the procedures to be used by every public or private general acute care hospital in the state for the examination and treatment of victims of sexual assault and attempted sexual assault, including child molestation, and the collection and preservation of evidence therefrom.

(2) The informational guide developed by the Office of Criminal Justice Planning shall be consulted where indicated in the protocol, as well as to gain knowledge about all aspects of examination and treatment of victims of sexual assault and child molestation.

SEC. 8. Section 13823.11 is added to the Penal Code, to read:

13823.11. The minimum standards for the examination and treatment of victims of sexual assault or attempted sexual assault, including child molestation and the collection and preservation of evidence therefrom include all of the following:

(a) Law enforcement authorities shall be notified.

(b) In conducting the physical examination, the outline indicated in the form adopted pursuant to subdivision (c) of Section 13823.5 shall be followed.

(c) Consent for a physical examination, treatment, and collection of evidence shall be obtained.

(1) Consent to an examination for evidence of sexual assault shall be obtained prior to the examination of a victim of sexual assault and shall include separate written documentation of consent to each of the following:

(A) Examination for the presence of injuries sustained as a result of the assault.

(B) Examination for evidence of sexual assault and collection of physical evidence.

(C) Photographs of injuries.

(2) Consent to treatment shall be obtained in accordance with usual hospital policy.

(3) A victim of sexual assault shall be informed that he or she may refuse to consent to an examination for evidence of sexual assault, including the collection of physical evidence, but that such a refusal is not a ground for denial of treatment of injuries and for possible pregnancy and veneral disease, if the person wishes to obtain treatment and consents thereto.

(4) Pursuant to Section 34.9 of the Civil Code, a minor may consent to hospital, medical, and surgical care related to a sexual assault without the consent of a parent or guardian.

(5) In cases of known or suspected child abuse, the consent of the parents or legal guardian is not required. In the case of suspected child abuse and nonconsenting parents, the consent of the local agency providing child protective services or the local law enforcement agency shall be obtained. Local procedures regarding obtaining consent for the examination and treatment of, and the collection of evidence from, children from child protective authorities shall be followed.

(d) A history of sexual assault shall be taken.

The history obtained in conjunction with the examination for evidence of sexual assault shall follow the outline of the form established pursuant to subdivision (c) of Section 13823.5 and shall include all of the following:

(1) A history of the circumstances of the assault.

(2) For a child, any previous history of child sexual abuse and an explanation of injuries, if different from that given by parent or person accompanying the child.

(3) Physical injuries reported.

(4) Sexual acts reported, whether or not ejaculation is suspected, and whether or not a condom or lubricant was used.

(5) Record of relevant medical history.

(e) Each adult and minor victim of sexual assault who consents to a medical examination for collection of evidentiary material shall have a physical examination which includes, but is not limited to, all of the following:

(1) Inspection of the clothing, body, and external genitalia for injuries and foreign materials.

(2) Examination of the mouth, vagina, cervix, penis, anus, and rectum, as indicated.

(3) Documentation of injuries and evidence collected.

Prepubital children shall not have internal vaginal or anal examinations unless absolutely necessary (this does not preclude careful collection of evidence using a swab).

(f) The collection of physical evidence shall conform to the

following procedures:

(1) Each victim of sexual assault who consents to an examination for collection of evidence shall have the following items of evidence collected, except where he or she specifically objects:

(A) Clothing worn during assault.

(B) Foreign materials revealed by an examination of the clothing, body, external genitalia, and pubic hair combings.

(C) Swabs and slides from the mouth, vagina, rectum, and penis, as indicated, to determine the presence or absence of sperm and sperm motility, and for genetic marker typing.

(2) Each victim of sexual assault who consents to an examination for the collection of evidence shall have reference specimens taken, except when he or she specifically objects thereto. A reference specimen is a standard from which to obtain baseline information (for example: pubic and head hair, blood, and saliva for genetic marker typing). These specimens shall be taken in accordance with the standards of the local criminalistics laboratory.

(3) A baseline gonorrhea culture, and syphillis serology, shall be taken, if indicated by the history of contact. Specimens for a pregnancy test shall be taken, if indicated by the history of contact.

(g) Preservation and disposition of physical evidence shall conform to the following procedures:

(1) All swabs and slides shall be air dried prior to packaging.

(2) All items of evidence including laboratory specimens shall be clearly labeled as to the identity of the source and the identity of the person collecting them.

(3) The evidence shall have a form attached which documents its chain of custody and shall be properly sealed.

(4) The evidence shall be turned over to the proper law enforcement agency.

SEC. 9. Notwithstanding Section 2231.5 of the Revenue and Taxation Code, this act does not contain a repealer, as required by that section; therefore, the provisions of this act shall remain in effect unless and until they are amended or repealed by a later enacted act.

SEC. 10. Reimbursement to local agencies and school districts for costs mandated by the state pursuant to this act shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code and, if the statewide cost of the claim for reimbursement does not exceed five hundred thousand dollars ($500,000), shall be made from the State Mandates Claims Fund.

SEC. 11. Notwithstanding Section 2231 or 2234 of the Revenue and Taxation Code and Section 6 of Article XIII B of the California Constitution, no appropriation is made by this act pursuant to these sections. It is recognized, however, that a local agency or school district may pursue any remedies to obtain reimbursement available to it under Chapter 4 (commencing with Section 17550) of Part 7 of Division 2 of Title 2 of the Government Code.

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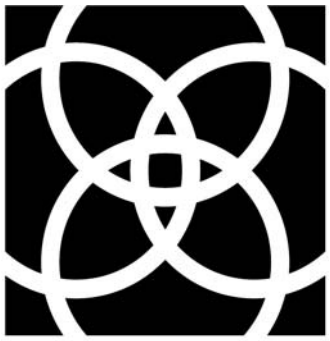
Appendix B

Penal Code 13823.93: California Medical Training Center

APPENDIX B



CALIFORNIA
MEDICAL
TRAINING
CENTER

Improving the Healthcare Response to Violence

California Medical Training Center (CMTC)
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The CMTC offers skill based training for performing quality forensic medical examinations for victims of sexual assault, child sexual abuse, child physical abuse and neglect, domestic violence and elder and dependent adult abuse. Training modalities include multi-day, skill based training and 1-8 hour lectures. Telecourses, case consultation, and Internet and CD-ROM self-instruction courses are under development. Hub training sites at UCLA, USC, and other locations for training delivery are available.

CMTC at UC Davis is the lead agency implementing this training program. CMTC is working in collaboration with subcontractors at UCLA and USC, and with the University Extension Programs at UC Davis and UCLA to deliver training.

Senate Bill No. 857

CHAPTER 860

An act to add Section 13823.93 to the Penal Code, relating to evidentiary examinations.

[Approved by Governor October 12, 1995. Filed with Secretary of State October 13, 1995.]

LEGISLATIVE COUNSEL'S DIGEST

SB 857, M. Thompson. Evidentiary examinations.

Existing law requires the Office of Criminal Justice Planning, in consultation with an advisory committee, to establish a protocol for the examination and treatment of victims of sexual assault and attempted sexual assault, including child molestation.

This bill would require 2 hospital-based training centers to be established through a competitive bidding process to train medical personnel on how to perform medical evidentiary examinations of victims of child abuse and neglect, sexual assault, elder abuse, or domestic violence. The bill would specify the characteristics and the responsibilities of the centers.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) The response of California's health care system to victims of violence, especially women and children, is inconsistent, in terms of both access to services and competence of health care workers. While services provided in some metropolitan centers may be excellent, access to trained medical practitioners is restricted and unevenly distributed throughout the state.

(b) Many rural, midsized counties and geographically large urban areas lack health professionals who are properly trained in providing evidentiary examinations, collection, preservation, and documentation of evidence, and interpretation of findings, and who are experienced in collaborating with law enforcement agencies and investigating social workers. This results in victims being improperly examined and law enforcement agencies lacking critical evidence.

(c) To appropriately respond to the medical care needs of victims of domestic violence, child abuse, elder abuse, and sexual assault, and to provide comprehensive, competent evidentiary examinations for use by law enforcement agencies, it is necessary to take immediate steps to ensure there are appropriately trained medical professionals throughout California.

SEC. 2. Section 13823.93 is added to the Penal Code, to read:

13823.93. (a) For purposes of this section, the following definitions apply:

(1) "Medical personnel" includes physicians, nurse practitioners, physician assistants, and nurses.

(2) To "perform a medical evidentiary examination" means to evaluate, collect, preserve, and document evidence, interpret findings, and document examination results.

(b) Two hospital-based training centers, one in northern California and one in southern California, shall be established through a competitive bidding process, to train medical personnel on how to perform medical evidentiary examinations of child victims of physical or sexual abuse or neglect. The centers also shall provide training for investigative and court personnel involved in dependency and criminal proceedings, on how to interpret the findings of medical evidentiary examinations.

The centers also shall train medical personnel on how to perform medical evidentiary examinations for victims of sexual assault, victims of spousal abuse, and victims of elder abuse.

The training centers shall be established over a two-year period, the center in northern California to be established in the first year and the center in southern California to be established in the second year. In addition, it is the intent of the Legislature that three consultation centers be established in future years, subject to an appropriation being made for that purpose.

(c) Training centers shall have all of the following criteria:

(1) Recognized expertise and experience in providing medical evidentiary examinations for child victims of sexual or physical abuse or neglect, or for sexual assault, elder abuse, and domestic violence victims, or both.

(2) Recognized expertise and experience implementing the protocol established pursuant to Section 13823.5.

(3) History of providing training, including, but not limited to, the clinical supervision of trainees and the evaluation of clinical competency.

(4) Recognized expertise and experience in the use of advanced medical technology in the evaluation of child victims of sexual or physical abuse or neglect, or of sexual assault, elder abuse, and domestic violence victims, or both.

(5) Significant history in working with professionals in the field of criminalistics.

(6) Established relationships with local crime laboratories, clinical laboratories, law enforcement agencies, district attorney's offices, child protective services, victim advocacy programs, and federal investigative agencies.

(7) The capacity for developing a telecommunication network between primary, secondary, and tertiary medical providers.

(8) History of research, particularly involving data bases, in the area of child physical and sexual abuse, sexual assault, elder abuse, or domestic violence.

(d) The training centers shall do all of the following:

(1) Develop and implement a standardized training program for medical personnel.

(2) Develop a telecommunication system network between the training centers and their respective outlying areas, including rural and midsized counties. This service shall provide case consultation to medical personnel, law enforcement, and the courts and provide continuing medical education.

(3) Provide ongoing initial, advanced, and specialized training programs.

(4) Develop guidelines for the reporting and management of child physical abuse and neglect, domestic violence, and elder abuse.

(5) Develop guidelines for evaluating the results of training for the medical personnel performing examinations.

(6) Provide training for law enforcement officers, district attorneys, public defenders, investigative social workers, and judges on medical evidentiary examination procedures and the interpretation of findings. This training shall be developed and implemented in collaboration with the Peace Officers Standards and Training Program, the California District Attorney's Association, the California Peace Officers Association, the California Police Chiefs Association, the California Sexual Assault Investigators Association, the California Welfare Directors Association, the California Coalition Against Sexual Assault, the Department of Justice, the Office of Criminal Justice Planning, the California State University at Fresno State Welfare Training Program, and the University of California extension programs.

(7) Promote an interdisciplinary approach in the assessment and management of child abuse and neglect, sexual assault, and domestic violence cases.

(8) Provide training in the dynamics of victimization, including, but not limited to, rape trauma syndrome, battered woman syndrome, and the effects of child abuse and neglect and elder abuse. This training shall be provided by individuals who are recognized as experts within their respective disciplines.

Appendix C

Form to Order Supplies

- OCJP 923
- OCJP 925
- OCJP 930
- OCJP 950

ATTACH MAILING LABEL HERE

APPENDIX C

OFFICE OF CRIMINAL JUSTICE PLANNING

FORM TO ORDER SUPPLIES OF OCJP 923, OCJP 925, OCJP 930, OR OCJP 950

Date: _____

Name of contact person: _____

Name of hospital/organization: _____

Street address: _____

City: _____

State, zip: _____

Telephone number of contact person: (_____) _____

Type of form requested:

OCJP 923: Forensic Medical Report:
Acute Adult/Adolescent Sexual Assault Examination
☐ Number of pads _____ (10 forms per pad)

OCJP 925: Forensic Medical Report:
Nonacute Child/Adolescent Sexual Abuse Examination
☐ Number of pads _____ (10 forms per pad)

OCJP 930: Forensic Medical Report:
Acute Child/Adolescent Sexual Abuse Examination
☐ Number of pads _____ (10 forms per pad)

OCJP 950: Forensic Medical Report:
Sexual Assault Suspect Examination
☐ Number of pads _____ (10 forms per pad)

Mail request to:
Business Management Branch
Office of Criminal Justice Planning
1130 K Street, Suite LL-60
Sacramento, CA 95814
(916) 324-9100

BMB USE ONLY

Date shipped: _____

Shipped by: _____

Input date: _____

Place
Stamp
Here

Business Services Branch
Office of Criminal Justice Planning
1130 K Street, Suite 300
Sacramento, CA 95814

Appendix D

DOJ SS 8572
Suspected Child Abuse Report

APPENDIX D

SUSPECTED CHILD ABUSE REPORT (11166 PC)

TO BE COMPLETED BY REPORTING PARTY

CASE IDENTIFICATION — *TO BE COMPLETED BY INVESTIGATING CPA*

VICTIM NAME: _____

REPORT NO./CASE NAME: _____

DATE OF REPORT: _____

A REPORTING PARTY

NAME/TITLE

ADDRESS

( ) PHONE _____ DATE OF REPORT _____ SIGNATURE OF REPORTING PARTY _____

B REPORT SENT TO

◯ POLICE DEPARTMENT ◯ SHERIFF'S OFFICE ◯ COUNTY WELFARE ◯ COUNTY PROBATION

AGENCY _____ ADDRESS _____

OFFICIAL CONTACTED _____ ( ) PHONE _____ DATE/TIME _____

C VICTIM

NAME (LAST, FIRST, MIDDLE) _____ ADDRESS _____ BIRTHDATE SEX RACE _____

PRESENT LOCATION OF CHILD _____ ( ) PHONE _____

SIBLINGS

1. _____ NAME BIRTHDATE SEX RACE
2. _____
3. _____
4. _____ NAME BIRTHDATE SEX RACE
5. _____
6. _____

D PARENTS

NAME (LAST, FIRST, MIDDLE) _____ BIRTHDATE SEX RACE _____

ADDRESS _____

( ) HOME PHONE _____ ( ) BUSINESS PHONE _____

NAME (LAST, FIRST, MIDDLE) _____ BIRTHDATE SEX RACE _____

ADDRESS _____

( ) HOME PHONE _____ ( ) BUSINESS PHONE _____

E INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET OR OTHER FORM AND CHECK THIS CIRCLE. ◯

1. _____ DATE/TIME OF INCIDENT _____ PLACE OF INCIDENT *(CHECK ONE)* ◯ OCCURRED ◯ OBSERVED

IF CHILD WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE:

◯ GROUP HOME OR INSTITUTION ◯ FOSTER CARE ◯ OTHER PLACEMENT (SPECIFY _____)

2. TYPE OF ABUSE: *(CHECK ONE OR MORE)* ◯ PHYSICAL ◯ MENTAL ◯ SEXUAL ASSAULT ◯ NEGLECT ◯ OTHER

3. NARRATIVE DESCRIPTION: _____

4. SUMMARIZE WHAT THE ABUSED CHILD OR PERSON ACCOMPANYING THE CHILD SAID HAPPENED: _____

5. EXPLAIN KNOWN HISTORY OF SIMILAR INCIDENT(S) FOR THIS CHILD: _____

SS 8572 4/81 *INSTRUCTIONS ON REVERSE*

Police or Sheriff — WHITE Copy; DOJ — PINK Copy; County Welfare or Probation — BLUE Copy; District Attorney — GREEN Copy; Reporting Party — YELLOW Copy

86 81980

Appendix E

List of California Rape Crisis Centers

APPENDIX E

CALIFORNIA RAPE CRISIS CENTERS

ALAMEDA

Bay Area Women Against Rape	Hotline:	510-845-7273
7700 Edgewater Drive, Suite 630	Office:	510-430-1298
Oakland, CA 94621	Fax:	510-430-2579
Highland Sexual Assault Center	Hotline:	510-548-0412
Highland General Hospital	Office:	510-437-4688
1411 East 31st Street	Fax:	510-437-8313
Oakland, CA 94602		
Tri-Valley Haven for Women	Hotline:	925-449-5842
P.O. Box 2190	Toll Free:	800-884-8119
Livermore, CA 94551	Office:	925-449-5845
	Fax:	925-449-2684

ALPINE (Services provided by agency in El Dorado County)

Womenspace Unlimited	Hotline:	530-544-4444
14810 Highway 89	Office:	530-694-1853
Markleeville, CA 96120	Fax:	530-694-2148

AMADOR

Operation Care	Hotline	209-257-0339
125 Schober Avenue	Office:	209-223-2897
Jackson, CA 95642	Fax:	209-223-2987

BUTTE (Also serves Glenn County)

Rape Crisis Intervention	Hotline:	530-342-7273
P.O. Box 423	Office:	530-891-1331
Chico, CA 95927	Fax:	530-891-3680

CALAVERAS

Human Resources Council	Hotline:	209-736-4011
Calaveras Women's Crisis Center	Office:	209-754-1300
P.O. Box 623	Fax:	209-754-1473
San Andreas, CA 95249		

COLUSA (Services provided by agency in Sutter County)

Casa de Esperanza, Inc.	Hotline:	530-674-2040
P.O. Box 56	Office:	530-674-5400
Yuba City, CA 95992	Fax:	530-674-3035

CONTRA COSTA

Rape Crisis Center	Hotline:	510-236-7273
2101 Van Ness Street	Office:	510-237-0113
San Pablo, CA 94806	Fax:	510-237-0177
Rape Crisis Center	Hotline:	925-798-7273
301 West 10th Street #3	Office:	925-706-4290
Antioch, CA 94509	Fax:	925-778-3091

DEL NORTE

North Coast Rape Crisis Team	Hotline:	707-465-2851
P.O. Box 1082	Office:	707-465-6961
Crescent City, CA 95531-1082	Fax:	707-465-5371
(send all mail to Eureka address listed under Humboldt County)		

EL DORADO

El Dorado Women's Center	Hotline:	530-626-1131
1248 Broadway, Suite C	Office:	530-626-1450
Placerville, CA 95667	Fax:	530-626-6895
Womenspace Unlimited (also serves Alpine County)	Hotline:	530-544-4444
2941 Lake Tahoe Boulevard, Suite A	Office:	530-544-2118
South Lake Tahoe, CA 96150	Fax:	530-542-7624

FRESNO

Rape Counseling Service of Fresno	Hotline:	559-222-RAPE
1060 Fulton Mall, Suite 901	Office:	559-497-2900
Fresno, CA 93721	Fax:	559-497-2911
West Fresno Crisis Center	Hotline:	800-891-2141
943 O Street	Office:	559-659-0232
Firebaugh, CA 93622	Fax:	559-659-0233

West Fresno Crisis Center	Hotline	800-891-2141
194 East Elm Street, Suite 102	Office	559-934-0915
Coalinga, CA 93210	Fax	559-934-0916

GLENN (Services provided by agency in Butte County)

Rape Crisis Intervention	Hotline:	530-342-7273
P.O. Box 423	Office:	530-891-1331
Chico, CA 95927	Fax:	530-891-3680

HUMBOLDT

North Coast Rape Crisis Team	Hotline:	707-445-2881
P.O. Box 543	Office:	707-443-2737
Eureka, CA 95502-0543	Fax:	707-443-2755

IMPERIAL

SURE Helpline Center	Hotline:	760-352-7273
395 Broadway, Suite 2	Office:	760-352-7873
El Centro, CA 92243	Fax:	760-352-7875

INYO

Wild Iris Women's Services of Bishop	Hotline:	877-873-7384
P.O. Box 697	Office:	760-872-1703
187 May Street	Fax:	760-872-3462
Bishop, CA 93515		

KERN

Alliance Against Family Violence and Sexual Assault	Hotline:	800-273-7713
P.O. Box 2054	Office:	661-322-0931
Bakersfield, CA 93303	Fax:	661-322-2916
Women's Center High Desert	Toll Free:	800-606-6319
P.O. Box 309	Hotline:	760-375-0745
Ridgecrest, CA 93556	Office:	760-371-1969
	Fax:	760-371-3449

KINGS

Kings Community Action Organization	Hotline:	877-727-3225
Sexual Assault Services Program	Office:	559-582-4386
1222 West Lacey Boulevard, Suite 201	Fax:	559-582-1536
Hanford, CA 93230		

LAKE

Sutter Lakeside Community Services	Hotline:	888-485-7733
896 Lakeport Boulevard	Office:	707-262-1611
Lakeport, CA 95453	Fax:	707-262-0344

LASSEN

Lassen Family Services, Inc.	Hotline:	530-257-5004
P.O. Box 701	Office:	530-257-4599
Susanville, CA 96130	Fax:	530-257-4205

LOS ANGELES

Sexual Assault Response Service	Hotline:	661-723-7273
Antelope Valley Hospital	Office:	661-949-5566
1206 West Avenue J, Suite 104	Fax:	661-949-5686
Lancaster, CA 93534		
East Los Angeles Women's Center	Hotline:	800-585-6231
1255 South Atlantic Boulevard	Office:	323-526-5819
Los Angeles, CA 90023	Fax:	323-526-5822
Center for the Pacific Asian Family, Inc.	Hotline:	800-339-3940
543 North Fairfax Avenue, Room 108	Office:	323-653-4045
Los Angeles, CA 90036	Fax:	323-653-7913
LACAAW	Hotline:	213-626-3393
(Los Angeles Commission on Assaults Against Women)	Office:	213-955-9090
605 West Olympic Boulevard #400	Fax:	213-955-9093
Los Angeles, CA 90015		
LACAAW -West San Gabriel Valley	Hotline:	626-793-3385
464 East Walnut Street, Suite 201	Office:	626-585-9166
Pasadena, CA 91101	Fax:	626-585-0447
Project SISTER Sexual Assault Crisis Services	Hotline:	909-626-HELP
P.O. Box 1390	Office:	909-623-1619
Claremont, CA 91711	Fax:	909-622-8389

Rosa Parks Sexual Assault Crisis Center	Hotline:	323-751-9245
Martin Luther King Legacy Association	Office:	323-751-9383
4182 South Western Avenue	Fax:	323-751-9384
Los Angeles, CA 90062		
Santa Monica Rape Treatment Center	Hotline:	310-319-4000
1250 Sixteenth Street	Office:	310-319-4503
Santa Monica, CA 90404	Fax:	310-319-4809
Sexual Assault Crisis Agency	Hotline:	562-597-2002
1703 Termino, Suite 103	Office:	562-494-5046
Long Beach, CA 90804	Fax:	562-494-1741
Valley Trauma Center	Hotline:	818-886-0453
California State University	Office:	818-756-5330
Northridge Foundation	Fax:	818-756-5443
7116 Sophia Avenue		
Van Nuys, CA 91406		
Valley Trauma Center - Northwest Los Angeles	Hotline:	661-253-0258
24359 San Fernando Road	Office:	661-253-1772
Santa Clarita, CA 91321	Fax:	661-253-2316
YWCA of Los Angeles - Compton Center	Hotline:	310-764-1403
1600 East Compton Boulevard	Office:	310-763-9995
Compton, CA 90221	Fax:	310-763-9590

MADERA

Madera County Action Committee	Hotline:	800-355-8989
Rape/Sexual Assault Victims Program	Office:	559-661-1000
1200 West Maple Street, Suite C	Fax:	559-661-8389
Madera, CA 93637		

MARIN

Rape Crisis Center of Contra Costa/Marin	Hotline:	415-924-2100
70 Skyview Terrace	Office:	415-492-5970
San Rafael, CA 94903	Fax:	415-492-5974

MARIPOSA (Services provided by agency in Merced County)

A Woman's Place	Hotline:	209-722-4357
P.O. Box 822	Office:	209-725-7900
Merced, CA 95341	Fax:	209-725-7908

MENDOCINO

Project Sanctuary, Inc.	Hotline:	707-463-HELP
P.O. Box 450	Office:	707-462-9196
Ukiah, CA 95482	Fax:	707-462-5869
Project Sanctuary, Inc.	Toll Free:	800-575-7191
P.O. Box 1224	Hotline:	707-964-HELP
Fort Bragg, CA 95437	Office:	707-961-1507
	Fax:	707-961-1539

MERCED (Also serves Mariposa County)

A Woman's Place	Hotline:	209-722-4357
P.O. Box 822	Office:	209-725-7900
Merced, CA 95341	Fax:	209-725-7908

MODOC

T.E.A.C.H., Inc.	Hotline:	530-233-4575
112 East 2nd Street	Office:	530-233-4575
Alturas, CA 96101	Fax:	530-233-4744

MONO

Wild Iris Women's Services	Hotline:	877-873-7384
P.O. Box 697	Office:	760-872-1703
Bishop, CA 93515	Fax:	760-872-3462

MONTEREY

Monterey Rape Crisis Center	Hotline:	831-375-4357
P.O. Box 2630	Office:	831-373-3955
Monterey, CA 93942	Fax:	831-373-3389
Women's Crisis Center	Hotline:	831-757-1001
427 Pajaro Street Suite 1	Office:	831-757-1002
P.O. Box 1805	Fax:	831-757-1381
Salinas, CA 93901		

NAPA

Volunteer Center of Napa County, Inc.	Hotline:	707-258-8000
1820 Jefferson Street	Office:	707-252-6222
Napa, CA 94559	Fax:	707-226-1217

NEVADA

Domestic Violence and Sexual Assault Coalition	Hotline:	530-272-3467
P.O. Box 484	Office:	530-272-2046
Grass Valley, CA 95945	Fax:	530-273-3780

ORANGE

Community Service Programs, Inc.	Hotline:	714-836-7400
Sexual Assault Victim Services-North	Hotline:	714-957-7273
700 Civic Center Drive West	Office:	714-834-4317
P.O. Box 1994	Fax:	714-834-2922
Santa Ana, CA 92702		
Community Service Programs, Inc.	Hotline:	949-831-9110
Sexual Assault Victim Services-South	Office:	949-752-1971
1821 East Dyer Road, Suite 200	Fax:	949-975-0250
Santa Ana, CA 92705-5700		

PLACER

Placer County Women's Center	Hotline:	530-652-6558
11990 Heritage Oak Place, Suite 7	Office:	530-885-0443
P.O. Box 5462	Fax:	530-885-2347
Auburn, CA 95603		
Crisis Intervention Services dba Tahoe Women's	Hotline:	530-546-3241
Services	Office:	530-546-7804
P.O. Box 1232	Fax:	530-546-8474
Kings Beach, CA 96143		

PLUMAS

Plumas Crisis Intervention & Resource Center	Hotline:	530-283-4333
P.O. Box 3668	Office:	530-283-5515
Quincy, CA 95971	Fax:	530-283-3539

RIVERSIDE

Hemet/San Jacinto Center Against Sexual Assault	Hotline:	909-652-8300
P.O. Box 2564	Office:	909-652-8300
Hemet, CA 92546	Fax:	909-652-0944

Harvest of Wellness Foundation	Hotline:	760-568-9071
Sexual Assault Services	Hotline:	760-568-2252
45-691 Monroe Street, Suite 10	Office:	760-347-8440
Indio, CA 92201	Fax:	760-347-0595
Riverside Area Rape Crisis Center	Hotline:	909-686-7273
1465 Spruce Street, Suite G	Office:	909-686-7273
Riverside, CA 92507	Fax:	909-686-0839

SACRAMENTO

W.E.A.V.E. (Women Escaping A Violent Environment)	Hotline:	916-920-2952
P.O. Box 161389	Office:	916-448-2321
Sacramento, CA 95816	Fax:	916-443-7183

SAN BENITO

Community Solutions for Children, Families & Individuals	Hotline:	831-637-SAFE
Community Sexual Assault Crisis Center	Office:	831-637-1094
494 Tres Pines Road	Fax:	831-636-3497
Hollister, CA 95023		

SAN BERNARDINO

San Bernardino Sexual Assault Services	Hotline:	909-885-8884
505 North Arrowhead Avenue, Suite 100	Office:	909-885-8884
San Bernardino, CA 92401-1221	Fax:	909-383-8478
Harvest of Wellness Foundation-Morongo Basin	Hotline:	800-954-8044
61-607 Twenty Nine Palms Hwy., Suite I	Office:	760-366-1393
Joshua Tree, 92252	Fax:	760-366-0181

SAN DIEGO

Escondido Youth Encounter Counseling and Crisis	Hotline:	760-747-6281
Services	Office:	760-747-6281
200 North Ash Street	Fax:	760-747-1635
Escondido, CA 92027		
Women's Resource Center	Hotline:	760-757-3500
1963 Apple Street	Office:	760-757-3500
Oceanside, CA 92054	Fax:	760-757-0680

Center of Community Solutions-Pacific Beach	Hotline:	858-272-1767
4508 Mission Bay Drive	Office:	858-272-5777
San Diego, CA 92109	Fax:	858-272-5361
Center of Community Solutions-East County	Hotline:	858-272-1767
7339 El Cajon Boulevard, Suite J	Office:	619-697-7477
La Mesa, CA 91941	Fax:	619-697-5678

SAN FRANCISCO

San Francisco Women Against Rape	Hotline:	415-647-7273
3543 - 18th Street #7	Office:	415-861-2024
San Francisco, CA 94110	Fax:	415-861-2092

SAN JOAQUIN

Women's Center of San Joaquin County	Hotline:	209-465-4997
620 North San Joaquin Street	Office:	209-941-2611
Stockton, CA 95202	Fax:	209-941-4963

SAN LUIS OBISPO

Sexual Assault Recovery and Prevention Center of San	Hotline:	805-545-8888
Luis Obispo County	Office:	805-545-8888
P.O. Box 52	Fax:	805-545-5841
San Luis Obispo, CA 93406		

SAN MATEO

Rape Trauma Services	Hotline:	650-692-RAPE
1860 El Camino, Suite 301	Office:	650-652-0598
Burlingame, CA 94010	Fax:	650-652-0596

SANTA BARBARA

North County Rape Crisis Services	Hotline:	805-736-7273
112 East Walnut	Office:	805-736-8535
P.O. Box 148	Fax:	805-736-8913
Lompoc, CA 93438		
and		
12 East Mill Street, Suite #203	Hotline:	805-928-3554
P.O. Box 6202	Office:	805-922-2994
Santa Maria, CA 93456	Fax:	805-928-2840

Santa Barbara Rape Crisis Center	Hotline:	805-564-3696
111 North Milpas Street	Office:	805-963-6832
Santa Barbara, CA 93103	Fax:	805-965-3271

SANTA CLARA

Community Solutions	Hotline:	408-779-2115
P.O. Box 546	Office:	408-779-2113
Morgan Hill, CA 95038-0546	Fax:	408-778-9672
YWCA of the Mid Peninsula	Hotline:	650-493-7273
Rape Crisis Center	Hotline:	408-245-3414
4161 Alma Street	Office:	650-494-0993
Palo Alto, CA 94306	Fax:	650-494-8307
Santa Clara Valley YWCA	Hotline:	408-287-3000
Center for Rape Prevention	Office:	408-295-4011
375 South Third Street	Fax:	408-295-0608
San Jose, CA 95112		

SANTA CRUZ

Women's Crisis Support	Hotline:	831-429-1478
1658 Soquel Drive, Suite A	Office:	831-477-4244
Santa Cruz, CA 95065	Fax:	831-477-4231

SHASTA

Shasta County Women's Refuge	Hotline:	530-244-0117
2280 Benton Drive, Bldg. A	Office:	530-244-0117
P.O. Box 994211	Fax:	530-244-2653
Redding, CA 96099-4211		

SIERRA

Plumas Crisis Intervention	Hotline:	877-215-2773
Sierra SAFE- Eastern County	Office:	530-993-1237
P.O. Box 207	Fax:	530-993-1239
513 Main Street		
Loyalton, CA 96118-0207		

Plumas Crisis Intervention
Sierra SAFE- Western County
204 Durgan Flat Road, Suite C
Courthouse Square
Downieville, CA 95936

Hotline: 877-332-2754
Office: 530-289-1728
Fax: 530-289-1727

SISKIYOU

Siskiyou Domestic Violence & Crisis Center
P.O. Box 688
Yreka, CA 96097

Hotline: 877-842-4068
Office: 530-842-6629
Fax: 530-842-9724

SOLANO

Solano Women's Crisis Center
1545 North Texas Street, Suite 201
Fairfield, CA 94533

Hotline: **Fairfield** 707-422-7273
Vallejo-Benecia 707-644-7273
Office: 707-422-7345
Fax: 707-422-7276

SONOMA

United Against Sexual Assault of Sonoma County
1420 Guerneville Road #1
Santa Rosa, CA 95402

Hotline: 707-545-7273
Office: 707-545-7270
Fax: 707-545-8136

STANISLAUS

Haven Women's Center of Stanislaus
619 13th Street, Suite 1
Modesto, CA 95354

Hotline: 209-527-5558
Office: 209-524-4331
Fax: 209-524-2045

SUTTER (also serves Colusa and Yuba Counties)

Casa de Esperanza, Inc.
P.O. Box 56
Yuba City, 95992

Hotline: 530-674-2040
Office: 530-674-5400
Fax: 530-674-3035

TEHEMA

Rape Crisis Intervention
P.O. Box 351
Red Bluff, CA 96080

Hotline: 530-342-7273
Office: 530-529-3980
Fax: 530-529-2061

TRINITY

Human Response Network	Hotline:	530-623-4357
100 Glen Road	Office:	530-623-2024
P.O. Box 2370	Fax:	530-623-6343
Weaverville, CA 96063		

TULARE

Family Services of Tulare County	Hotline:	559-732-7273
815 West Oak Street, Suite B	Office:	559-732-7371
Visalia, CA 93291	Fax:	559-741-7314
and		
Family Services of Tulare County	Hotline:	559-784-RAPE
(Porterville Satellite)	Office:	559-782-5115
30 East Morton	Fax:	559-782-5117
Porterville, CA 93278		

TUOLUMNE

Mountain Women's Resource Center	Hotline:	209-533-3401
514 South Stewart Street	Office:	209-588-9305
P.O. Box 1154	Fax:	209-588-9272
Sonora, CA 95370		

VENTURA

Coalition Against Domestic & Sexual Violence	Hotline:	805-656-1111
1030 North Ventura Road	Office:	805-983-6014
Oxnard, CA 93030	Fax:	805-983-6240

YOLO

Sexual Assault & Domestic Violence Center	Hotline:	**Davis**
927 Main Street, Suite A		530-758-8400
Woodland, CA 95695		**Woodland**
		530-662-1133
		Sacramento
		916-371-1907
	Office:	530-661-6336
	Fax:	530-661-3021

YUBA (Services provided by agency in Sutter County)

Casa de Esperanza, Inc.	Hotline:	530-674-2040
P.O. Box 56	Office:	530-674-5400
Yuba City, CA 95992	Fax:	530-674-3035

Appendix F

List of California Victim/Witness Assistance Centers

Appendix F
CALIFORNIA VICTIM/WITNESS ASSISTANCE CENTERS

ALAMEDA COUNTY

Victim/Witness Assistance Center
Alameda County District Attorney's Office
1401 Lakeside Drive, Suite 802
Oakland, California 94612

MAIN: (510) 272-
BOSCO:(510) 272-6176
FAX: (510) 208-9565

ALPINE COUNTY

Victim/Witness Assistance Center
County of Alpine Probation Department
P.O. Box 458
Markleeville, California 96120

(530) 694-2192
FAX: (530) 694-2213

AMADOR COUNTY

Victim/Witness Assistance Center
Amador County District Attorney's Office
45 Summit Street
Jackson, California 95642

(209) 223-6474
FAX: (209) 223-6475

BUTTE COUNTY

Victim/Witness Assistance Center
Butte County Probation Department
2279 Del Oro Avenue, Suite C
Oroville, California 95965

(530) 538-7340
FAX: (530) 534-8301

CALAVERAS COUNTY

Victim/Witness Assistance Center
Calaveras County District Attorney's Office
891 Mountain Ranch Road
San Andreas, California 95249

(209) 754-6565
FAX: (209) 754-6645

COLUSA COUNTY

Victim/Witness Assistance Center
Colusa County Probation Department
532 Oak Street (530) 458-0659
Colusa, California 95932 FAX: (530) 458-3009

CONTRA COSTA COUNTY

Victim/Witness Assistance Center
Contra Costa County Probation Department (925) 313-4170
50 Douglas Drive, Suite 202 (800) 648-0600
Martinez, California 94553-8500 FAX: (925) 313-4178

San Pablo Victim/Witness Office
West County Office
2555 El Portal Drive (510) 374-3272
San Pablo, California 94806 FAX: (510) 374-3441

DEL NORTE COUNTY

Victim/Witness Assistance Center
Del Norte County District Attorney's Office
450 H Street (707) 464-7273
Crescent City, California 95531 FAX: (707) 464-2975

EL DORADO COUNTY

Placerville
Victim/Witness Assistance Center Placerville
El Dorado County District Attorney's Office (888) 422-6492
515 Main Street (530) 621-6492
Placerville, California 95667 FAX: (530) 295-2602

South Lake Tahoe
Victim/Witness Assistance Center South Lake Tahoe
El Dorado County District Attorney's Office
1360 Johnson Boulevard, Suite 105 (530) 573-3337
South Lake Tahoe, California 96150 FAX: (530) 544-6413

FRESNO COUNTY

Victim/Witness Assistance Center
Fresno County Probation Department (Adult)
2220 Tulare, Suite 1126
Fresno County Plaza — (559) 488-3425
Fresno, California 93721 — FAX: (559) 488-3826

GLENN COUNTY

Victim/Witness Assistance Center
HRA Community Action Division — (800) 287-8711
420 East Laurel Street — (530) 934-6510
Willows, California 95988 — FAX: (530) 934-6650

HUMBOLDT COUNTY

Victim/Witness Assistance Center
Humboldt County District Attorney's Office
714 Fourth Street — (707) 445-7417
Eureka, California 95501 — FAX: (707) 445-7490

IMPERIAL COUNTY

Victim/Witness Assistance Center
Imperial County Probation Department
217 South Tenth, Building B — (760) 339-4357
El Centro, California 92244 — FAX: (760) 353-3292

INYO COUNTY

Inyo County Victim/Witness Assistance Center
Bishop Victim/Witness Office
301 West Line Street, Suite C — (760) 873-6669
Bishop, California 93514 — FAX: (760) 873-8359

Inyo County District Attorney's Office
P.O. Drawer D — (760) 878-0282
Independence, California 93526 — FAX: (760) 878-2383

KERN COUNTY

Victim/Witness Assistance Center
Kern County Probation Department
1415 Truxtun Avenue, 6th Floor, Room 603 (661) 868-4535
Bakersfield, California 93301 FAX: (661) 868-4586

KINGS COUNTY

Victim/Witness Assistance Center
Kings County Probation Department
Government Center, 1400 Lacey Boulevard (559) 582-3211 X-2640
Hanford, California 93230 FAX: (559) 584-7038

LAKE COUNTY

Victim/Witness Assistance Center
Lake County District Attorney's Office (707) 262-4282
420 Second Street FAX: (707) 262-5851
Lakeport, California 95453

Mailing Address
255 North Forbes Street
Lakeport, California 95453

LASSEN COUNTY

Victim/Witness Assistance Center
Lassen County District Attorney's Office
Courthouse, 220 South Lassen Street, Suite 8 (530) 251-8283
Susanville, California 96130 FAX: (530) 257-9009

LOS ANGELES COUNTY

Victim/Witness Assistance Center
Los Angeles County District Attorney's Office
3204 Rosemead Boulevard, Suite E (626) 927-2525
El Monte, California 91731 FAX: (626) 569-9541

LOS ANGELES COUNTY (Continued)

Central Victim/Witness Office
210 West Temple, No. 12-514
Los Angeles, California 90012
(213) 974-7399
(213) 974-1623 or 974-1639
FAX: (213) 625-8104

El Monte Victim/Witness Office
3220 North Rosemead Boulevard
El Monte, California 91731
(626) 572-6366
(800) 492-5944
FAX: (626) 280-0817

El Monte Victim/Witness
11234 East Valley Boulevard
El Monte, California 91731
(626) 350-4583
FAX: (626) 442-6543

Sexual Crimes/Child Abuse Unit
Hall of Records
320 West Temple Street, Room 740
Los Angeles, California 90012
(213) 974-3801
FAX: (213) 625-2810

Carson Sheriff
21356 South Avalon Boulevard
Carson, California 90745
(310) 830-8376
FAX: (310) 847-8368

Compton Courthouse
200 West Compton Boulevard, Room 700
Compton, California 90220
(310) 603-7579 or 630-7574
(310) 603-7127
FAX: (310) 603-0493

Statutory Rape Program
Hall of Records
320 West Temple Street, No. 740
Los Angeles, California 90012
(213) 974-3908
FAX: (213) 625-2810

Inglewood Courthouse
One Regent Street, Room 405
Inglewood, California 90301
(310) 419-6764
(310) 419-5175
FAX: (310) 674-7839

Long Beach Courthouse
415 West Ocean Boulevard, Room 305
Long Beach, California 90802
(562) 491-6347
(562) 491-6310
FAX: (562) 436-9849

Santa Monica Courthouse
1725 Main Street, Room 228
Santa Monica, California 90401
(310) 260-3678
FAX: (310) 458-6518

LOS ANGELES COUNTY (Continued)

Torrance Courthouse
825 Maple Avenue — (310) 222-3599
Torrance, California 90503 — FAX: (310) 783-1684

Antelope Valley Courthouse
1110 West Avenue J — (661) 945-6464
Lancaster, California 93534 — FAX: (661) 945-6179

Hollywood LAPD
1358 North Wilcox Avenue — (323) 871-1184
Los Angeles, California 90028 — FAX: (213) 485-8891

Industry Sheriff
150 North Hudson Avenue — (626) 934-3004
City of Industry, California 91744 — FAX: (626) 333-1895

Pasadena Courthouse
300 East Walnut Street, Room 107 — (626) 356-5714 or 356-5715
Pasadena, California 91101 — FAX: (626) 796-3176

Pomona Courthouse
400 Civic Center Drive, Room 201 — (909) 620-3381 or 620-3382
Pomona, California 91766 — FAX: (909) 629-6876

San Fernando Area
900 3rd Street, Room G14 — (818) 898-2406
San Fernando, California 91340 — FAX: (818) 898-2743

Temple City Sheriff
8838 East Las Tunas Drive — (626) 292-3333
Temple City, California 91780 — FAX: (626) 287-7353

Van Nuys Courthouse
6230 Sylmar Avenue, 5th Floor — (818) 374-3075
Van Nuys, California 91401 — FAX: (818) 782-5349

Central LAPD
251 East Sixth Street — (213) 627-1619
Los Angeles, California 90014 — FAX: (213) 847-2956

East Los Angeles Courthouse

214 South Fetterly Avenue, Room 201 (323) 780-2045
Los Angeles, California 90022 FAX: (323) 269-4869

LOS ANGELES COUNTY (Continued)

Huntington Park Area Office
2958 East Florence Avenue (323) 586-6337
Huntington Park, California 90255 FAX: (323) 584-9055

Lakewood Sheriff
5130 North Clark Avenue (562) 920-5156
Lakewood, California 90712 FAX: (562) 867-4712

Norwalk Courthouse
12720 Norwalk Boulevard, Room 201 (562) 807-7230
Norwalk, California 90650 FAX: (562) 929-7626

Rampart LAPD
303 South Union (213) 483-6731
Los Angeles, California 90057 FAX: (213) 207-2108

Southeast LAPD
145 West 108th Street (323) 754-8064
Los Angeles, California 90061 FAX: (323) 485-8340

Southwest LAPD
1546 Martin Luther King Boulevard (323) 296-8645
Los Angeles, California 90062 FAX: (323) 473-6757

California Hospital
1423 South Grand Avenue
Los Angeles, California 90015 (213) 742-6022

Eastlake Juvenile Office
1601 Eastlake Avenue, Room 132 (323) 226-8918
Los Angeles, California 90033 FAX: (323) 223-6248

Family Violence Division
Criminal Courts Bldg. (213) 974-7410
210 West Temple Street, Room 603 (213) 974-3879
Los Angeles, California 90012 FAX: (213) 217-4992

Stalking & Threat Management Team
Hall of Records

320 West Temple Street, Room 780-41 (213) 893-0896
Los Angeles, California 90012 (213) 626-2758

LOS ANGELES COUNTY (Continued)

Whittier Branch Office
7339 South Painter Avenue, Room 200 (562) 907-3189
Whittier, California 90602 FAX: (562) 696-9631

Airport Branch Office
11701 South La Cienega Boulevard, Room 611 (310) 727-6515
Los Angeles, California 90045 FAX: (310) 727-0565

Child Abuse Crisis Center
Harbor-UCLA Medical Center
1000 West Carson Street, Box 460 Trailer N-26 (310) 222-1208
Torrance, California 90509 FAX: (310) 320-7849

East L.A. Sherriff
5019 East Third Street (323) 981-5024
Los Angeles, California 90022 FAX: (323) 267-0637

LOS ANGELES CITY (Subgrant to Los Angeles County Victim/Witness)

Victim/Witness Assistant Center
Los Angeles City Attorney's Office (213) 485-6976
312 South Hill Street, Third Floor ADMINISTRATION: (213) 485-5009
Los Angeles, California 90013 FAX: (213) 847-8667

Victim Assistance Program
Special Emphasis Korean Outreach Project
312 South Hill Street, Second Floor
Los Angeles, California 90013 (213) 485-9889

North Hollywood Station LAPD
Victim Assistance Program
11640 Burbank Boulevard (818) 623-4056
North Hollywood, California 91601 FAX: (818) 623-4121

Northeast Area Station LAPD
Victim Assistance Program
3353 San Fernando Road (213) 485-3240

Los Angeles, California 90065 FAX: (213) 847-0669

LOS ANGELES CITY (Continued)

Victim Assistance Program
San Pedro City Hall
638 South Beacon Street, Room 326 (310) 732-4611
San Pedro, California 90731 FAX: (310) 732-4618

Victim Assistance Program
Van Nuys City Hall
14410 Sylvan Street, Room 117 (818) 756-8488
Van Nuys, California 91401 FAX: (818) 756-9444

Wilshire Area Station LAPD
Victim Assistance Program
4861 Venice Boulevard (213) 847-1991
Los Angeles, California 90019 FAX: (213) 847-0668

West Los Angeles Station LAPD
Victim Assistance Program
1663 Butler Avenue (310) 575-8441
West Los Angeles, California 90025 FAX: (310) 575-6710

Newton Area Station LAPD
Victim Assistance Program
3400 South Central Avenue (323) 846-5374
Los Angeles, California 90011 FAX: (323) 846-6586

77th Street Area Station LAPD
Victim Assistance Program
7600 South Broadway (213) 485-8848
Los Angeles, California 90003 FAX: (213) 847-0667

Hollenbeck Area Station LAPD
Victim Assistance Program
2111 East First Street (323) 526-3190
Los Angeles, California 90033 FAX: (323) 485-8401

MADERA COUNTY

Victim/Witness Assistance Center
Madera County Action Committee, Inc.
1200 West Maple Street, Suite C (559) 661-1000
Madera, California 93637 FAX: (559) 661-8389

MARIN COUNTY

Victim/Witness Assistance Center
Marin County District Attorney's Office (415) 499-6450
3501 Civic Center Drive, Room 130 FAX: (415) 499-3719
San Rafael, California 94903

MARIPOSA COUNTY

Victim/Witness Assistance Center
Mariposa County District Attorney's Office
5078 Bullion Street (209) 742-7441
P.O. Box 748 FAX: (209) 742-5780
Mariposa, California 95338

MENDOCINO COUNTY

Victim/Witness Assistance Center
Mendocino County District Attorney's Office
Courthouse, Room 10
100 North State Street (707) 463-4218
P.O. Box 144 FAX: (707) 463-4687
Ukiah, California 95482

Fort Bragg Victim/Witness Office
700 South Franklin Street
Fort Bragg, California 95437 (707) 961-2411

MERCED COUNTY

Victim/Witness Assistance Center
Merced County District Attorney's Office (209) 725-3600
2222 M Street FAX: (209) 725-3669
Merced, California 95340

MODOC COUNTY

Victim/Witness Assistance Center
Modoc County District Attorney's Office — (530) 233-6212
P.O. Box 1171 — FAX: (530) 233-4067
Alturas, California 96101

MONO COUNTY

Victim/Witness Assistance Center
P.O. Box 2053 — (760) 924-5424
Mammoth Lakes, California 93546 — FAX: (760) 924-5418

Bridgeport Victim/Witness Office
P.O. Box 617
Bridgeport, California 93517 — (619) 932-5223

MONTEREY COUNTY

Victim/Witness Assistance Center
Monterey County District Attorney's Office
P.O. Box 1131 — (831) 755-5072
Salinas, California 93902 — FAX: (831) 755-5068

Monterey Victim/Witness Office — Monterey (Vacant)
1200 Aquajito Road, Room 301 — (831) 647-7770
Monterey, California 93940 — FAX: (831) 647-7772

NAPA COUNTY

Victim/Witness Assistance Center
Napa County Volunteer Center
1820 Jefferson Street — (707) 252-6222
Napa, California 94559 — FAX: (707) 226-5179

NEVADA COUNTY

Victim/Witness Assistance Center
Nevada County Probation Department
201 Church Street, Suite 10 — (530) 265-1246
Courthouse, Second Floor — (530) 265-1247

Nevada City, California 95959 FAX: (530) 265-7201

ORANGE COUNTY

Victim/Witness Assistance Administrative Center
Community Service Programs, Inc. (949) 975-0244
1821 East Dyer, Suite 200 FAX: (949) 975-0250
Santa Ana, California 92705

Superior Court
Central Justice Center
700 Civic Center Drive West
P.O. Box 1994
Santa Ana, California 92702 (714) 834-4350

North Justice Center
1275 North Berkeley Avenue
Fullerton, California 92635 (714) 773-4575

South Justice Center
30143 Crown Valley Parkway
Laguna Niguel, California 92677 (714) 249-5037

West Justice Center
8141 13th Street
Westminster, California 92683 (714) 896-7188

Harbor Justice Center
4601 Jamboree Boulevard, Suite 103
Newport Beach, California 92660 (949) 476-4855

Lamoreaux Justice Center
301 The City Drive
Orange, California 92668 (714) 935-7074

PLACER COUNTY

Victim/Witness Assistance Program

Placer County District Attorney's Office
11795 Education Street, No. 102 (530) 889-5790
Auburn, California 95602 FAX: (530) 889-5794

PLUMAS COUNTY

Victim/Witness Assistance Center
Plumas County Probation Department (530) 283-6285
75 Court Street, Suite A FAX: (530) 283-6226
Quincy, California 95971

RIVERSIDE COUNTY

Victim/Witness Assistance Center
Riverside County District Attorney's Office (909) 955-5450
4075 Main Street, First Floor FAX: (909) 955-5640
Riverside, California 92501

Banning Victim/Witness Office
Western Riverside County
135 North Alessandro, Room 205
Banning, California 92220 (909) 849-6218

Blythe Victim/Witness Office
Eastern Riverside County
225 North Broadway
Blythe, California 92225 (935) 922-2196

Hemet Victim/Witness Office
Western Riverside County
910 North State Street
Hemet, California 92543 (909) 766-2385

Indio Victim/Witness Office
Eastern Riverside County
82-675 Highway 111, Fourth Floor
Indio, California 92201 (760) 863-8408

Riverside Victim/Witness Juvenile Office

Western Riverside County
9991 County Farm Road
Riverside, California 92503 (909) 358-4152

Perris Victim/Witness Office
Western Riverside County
135 North D Street
Perris, California 92370 (909) 940-6757

SACRAMENTO COUNTY

Victim/Witness Assistance Center
Sacramento County District Attorney's Office
901 G Street (916) 874-5701
Sacramento, California 95814 FAX: (916) 874-5271

SAN BENITO COUNTY

Victim/Witness Assistance Center
San Benito County District Attorney's Office
419 Fourth Street (831) 637-8244
Hollister, California 95023 FAX: (831) 636-4126

SAN BERNARDINO COUNTY

Victim/Witness Assistance Center (909)478-7448
San Bernardino County District Attorney's Office VW Center (909) 387-6540
316 North Mountain View Avenue DA Office: (909) 387-8309
San Bernardino, California 92415 FAX: (909) 387-6313

Rancho Cucamonga Victim/Witness Office (909) 945-4234
8303 North Haven Avenue FAX: (909) 945-4035
Rancho Cucamonga, California 91730

Victorville Victim/Witness Office
14455 Civic Drive
Victorville, California 92392 (619) 243-8619

Barstow Victim/Witness Office
235 East Mountain View
Barstow, California 92311 (619) 256-4802

SAN DIEGO COUNTY

Victim/Witness Assistance Center
San Diego County District Attorney's Office
330 West Broadway, Suite 880 (619) 531-4287
San Diego, California 92101 FAX: (619) 531-3759

Mailing Address
P.O. Box X-121011
San Diego, California 92112

District Attorney's Office
San Diego County Courthouse
Hall of Justice
330 West Broadway, Suite 880
San Diego, California 92101 (619) 531-4041

Chula Vista Victim/Witness Office
500 Third Avenue
Chula Vista, California 92010 (619) 691-4539

El Cajon Victim/Witness Office
250 East Main Street, 5th Floor
El Cajon, California 92020 (619) 441-4538

Vista Victim/Witness Office
325 South Melrose, Suite 5000
Vista, California 92083 (760) 806-4079

Juvenile Victim/Witness Office
2851 Meadowlark Drive
San Diego, California 92123 (858) 694-4595

San Diego Police Department
1401 Broadway
San Diego, California 92101 (619) 531-2772 or
(619) 531-2773

SAN FRANCISCO COUNTY AND CITY

Victim/Witness Assistance Center

San Francisco County District Attorney's Office (415) 553-9044
850 Bryant Street, Room 320 FAX: (415) 553-1034
San Francisco, California 94103

SAN JOAQUIN COUNTY

Victim/Witness Assistance Center
San Joaquin County District Attorney's Office
222 East Weber Avenue, Room 245 (209) 468-2500
Stockton, California 95202 FAX: (209) 468-2521

SAN LUIS OBISPO

Victim/Witness Assistance Center
San Luis Obispo County District Attorney's Office
County Government Center, Room 121 (805) 781-5821
San Luis Obispo, California 93408 FAX: (805) 781-5828

SAN MATEO COUNTY

Victim/Witness Assistance Center
San Mateo County Probation Department
1024 Mission Road (650) 877-5492
South San Francisco, California 94080 FAX: (650) 877-7001

SANTA BARBARA COUNTY

Victim/Witness Assistance Center
Santa Barbara County District Attorney's Office (805) 568-2408
118 East Figueroa Street FAX: (805) 568-2453
Santa Barbara, California 93101

Santa Maria Victim/Witness Office
312 East Cook Street
Santa Maria, California 93454 (805) 346-7529

Lompoc Victim/Witness Office
115 Civil Plaza Center
Lompoc, California 93436 (805) 737-7910
Note: Office is open on a part-time basis

SANTA CLARA COUNTY

Santa Clara County Victim/Witness Assistance Center
National Conference for Community and Justice (408) 295-2656
777 North First Street, Suite 220 FAX: (408) 289-5430
San Jose, California 95112

SANTA CRUZ COUNTY

Victim/Witness Assistance Center
Santa Cruz County District Attorney's Office
701 Ocean Street, Room 200 (831) 454-2623
Santa Cruz, California 95060 FAX: (831) 454-2612

SHASTA COUNTY

Victim/Witness Assistance Center
Shasta County Probation Department
1525 Court Street (530) 225-5220
Redding, California 96001 FAX: (530) 245-6334

SIERRA COUNTY

Victim/Witness Assistance Center
Sierra County Probation Department
P.O. Box 886 (530) 993-4617
Loyalton, California 96118 FAX: (530) 993-0415

SISKIYOU COUNTY

Victim/Witness Assistance Center
Siskiyou County District Attorney's Office
P.O. Box 986 (530) 842-8145
Yreka, California 96097 FAX: (530) 842-8137

SOLANO COUNTY

Victim/Witness Assistance Center
Solano County District Attorney's Office
Hall of Justice
600 Union Avenue (707) 421-6844
Fairfield, California 94533 FAX: (707) 421-7986

Solano Victim/Witness Office
Solano County Justice Building
321 Tuolumne Street (707) 554-5400
Vallejo, California 94590 FAX: (707) 554-5654

SONOMA COUNTY

Victim/Witness Assistance Center
Sonoma County Probation Department (707) 565-8250
1000 Coddingtown Center 95401 FAX: (707) 565-8260
P.O. Box 11719
Santa Rosa, California 95406-1719

STANISLAUS COUNTY

Victim/Witness Assistance Center
Stanislaus County District Attorney's Office
P.O. Box 442 (209) 525-5550
Modesto, California 95353 FAX: (209) 525-5545

SUTTER COUNTY

Victim/Witness Assistance Center
Sutter County District Attorney's Office
P.O. Box 1555
204 C Street, Courthouse Annex (530) 822-7345
Yuba City, California 95992 FAX: (530) 822-7337

TEHAMA COUNTY

Victim/Witness Assistance Center
County of Tehama
District Attorney (530) 527-4296

P.O. Box 519 FAX: (530) 527-4735
Red Bluff, California 96080

TRINITY COUNTY

Victim/Witness Assistance Center
Probation
County of Trinity Probation Department
P.O. Box 158 (530) 623-1205
Weaverville, California 96093 FAX: (530) 623-1237

TULARE COUNTY

Victim/Witness Assistance Center
Tulare County Assistance Center
2350 Burrel Avenue, Room 226 (559) 733-6754
Visalia, California 93291 FAX: (559) 730-2931

TUOLUMNE COUNTY

Victim/Witness Assistance Center
Tuolumne County District Attorney's Office
2 South Green Street (209) 533-5642
Sonora, California 95370 FAX: (209) 533-6574

VENTURA COUNTY

Victim/Witness Assistance Center RECEPTION: (805) 654-3622
Ventura County District Attorney's Office DEBBIE: (805) 654-2532
800 South Victoria Avenue, No. 311 FAX: (805) 654-3046
Ventura, California 93009

YOLO COUNTY

Victim/Witness Assistance Center
Yolo County District Attorney's Office
301 Second Street (530) 666-8187

Woodland, California 95695 FAX: (530) 666-8185

YUBA COUNTY

Victim/Witness Assistance Center
Yuba County Probation Department
938 14th Street (530) 741-6275
Marysville, California 95901 FAX: (530) 749-7913

FEDERAL VICTIM/WITNESS CENTERS

Federal Victim/Witness Coordinator (916) 554-2776 or
U.S. Attorney, Eastern District (916) 554-2783
555 Capitol Mall, 15th Floor FAX: (916) 554-2100
Sacramento, California 95814

Federal Victim/Witness Coordinator
ATF Special Operations
650 Mass Avenue. NW, Room 7330 (213) 894-7627
Los Angeles, California 90012 FAX: (213) 894-6436

Federal Victim/Witness Coordinator (800) 544-1106 ext. 5527
U.S. Attorney, Southern District (619) 557-5527
880 Front Street, Room 6293 FAX: (619) 557-5782
San Diego, California 92101-8893

Federal Victim/Witness Coordinator (800) 447-5738
Department of Justice, Antitrust Division (415) 436-6660
450 Golden Gate Avenue, Room 10-0101, Box 36046 FAX: (415) 436-6687
San Francisco, California 94102-3478

CALIFORNIA YOUTH AUTHORITY

(916) 262-1534
4241 Williamsbourgh Drive, Suite 214 (916) 262-1181
Sacramento, California 95823

Appendix G

List of California Public Crime Laboratories

Appendix G
California Public Crime Laboratories

ALAMEDA COUNTY

Alameda County Sheriff's Department
Crime Laboratory
15001 Foothill Blvd
San Leandro, CA 94578
Office: 510-667-7700
Fax: 510-483-6791

Oakland Police Department Crime Laboratory
455 7th Street, Room 608
Oakland, CA 94607
Office: 510-238-3386
Fax: 510-238-6555

CONTRA COSTA COUNTY

Contra Costa County Office of the Sheriff
Forensic Services Division
1122 Escobar Street
Martinez, CA 94553
Office: 925-335-1600
Fax: 925-646-2913

FRESNO COUNTY

Fresno County Sheriff's Department
Forensic Services Division
1256 East Divisadero
Fresno, CA 93721
Office: 559-233-0308
Fax: 559-233-1149

KERN COUNTY

Kern County District Attorney's Office
Regional Criminalistics Laboratory
1300 18th Street, 4th Floor
Bakersfield, CA 93301
Office: 661-868-5367
Fax: 661-868-5675

LOS ANGELES COUNTY

Long Beach Police Department Crime Laboratory
400 West Broadway
Long Beach, CA 90802
Office: 562-570-7205
Fax: 562-570-6109

Los Angeles County Sheriff's Department
Scientific Services Bureau
2020 West Beverly Boulevard
Los Angeles, CA 90057
Office: 213-974-4601
Fax: 213-413-7637

Los Angeles Police Department Scientific Investigations
Office: 213-847-0044

ALAMEDA COUNTY

Division
555 Ramirez Street, Sp. 270
Los Angeles, CA 90012

Fax: 213-847-0040

ORANGE COUNTY

	Office:	714-834-6380
Orange County Sheriff-Coroner Forensic Science Services 320 Flower Street Santa Ana, CA 92703	Fax:	714-834-4519
Huntington Beach Police Department Crime Laboratory 2000 Main Street Huntington, CA 92648	Office: Fax:	714-536-5682 714-536-7172

SACRAMENTO COUNTY

Sacramento County Laboratory of Forensic Services 4800 Broadway, Suite 200 Sacramento, CA 95820	Office: Fax:	916-874-9240 916-874-9620

SAN BERNADINO COUNTY

San Bernardino County Sheriff's Department Crime Laboratory 200 South Lena Road San Bernardino, CA 92415	Office: Fax:	909-387-8849 909-387-3361

SAN DIEGO COUNTY

San Diego County Sheriff's Department Crime Laboratory 5255 Mt. Etna Drive San Diego, CA 92117	Office: Fax:	619-467-4455 619-467-4650
El Cajon Police Department Crime Laboratory 100 Fletcher Parkway El Cajon, CA 92020	Office: Fax:	619-579-3354 619-441-1330
San Diego Police Department Crime Laboratory 1401 Broadway, MS 725 San Diego, CA 92101	Office: Fax:	619-531-2579 619-531-2950

SAN FRANCISCO COUNTY

San Francisco Police Department Forensic Services Division 850 Bryant Street, Room 435 San Francisco, CA 94103	Office: Fax:	415-671-3200 415-671-3280

SAN MATEO COUNTY

San Mateo County Sheriff's Department
Forensic Laboratory
31 Tower Road
San Mateo, CA 94402-4097

Office: 650-312-5306
Fax: 650-312-8867

SANTA CLARA COUNTY

Santa Clara County District Attorney Crime Laboratory
1557 Berger Drive, Suite B-2
San Jose, CA 95112

Office: 408-299-2220
Fax: 408-298-7501

VENTURA COUNTY

Ventura County Sheriff Crime Laboratory
800 South Victoria Avenue
Ventura, CA 93009

Office: 805-662-6878
Fax: 805-650-4080

California Department of Justice Bureau of Forensic Services (BFS)

Berkeley DNA Laboratory 626 Bancroft Way Berkeley, CA 94710	Office: Fax:	510-540-2434 510-540-2701
Chico Laboratory 3870 Morrow Lane, Suite A Chico, CA 95928	Office: Fax:	916-895-5024 916-895-4657
Eureka Laboratory 1011 West Wabash Eureka, CA 95501	Office: Fax:	707-445-6682 707-445-6688
Freedom Laboratory 440 Airport Boulevard, Building A Watsonville, CA 95076	Office: Fax:	408-761-7620 408-761-7629
French Camp Laboratory 1001 West Mathews Road French Camp, CA 95231	Office: Fax:	209-948-7554 209-948-7714
Fresno Laboratory 6014 North Cedar Fresno, CA 93710	Office: Fax:	209-278-2982 209-297-3544
Modesto Laboratory 2213 Blue Gum Avenue Modesto, CA 95351	Office: Fax:	209-576-6215 209-526-4223
Redding Laboratory 11745 Old Oregon Trail Redding, CA 96003	Office: Fax:	916-225-2830 916-241-8409
Riverside Laboratory 1500 Castellano Road Riverside, CA 92509	Office: Fax:	909-782-4170 909-782-4128
Sacramento Laboratory 4949 Broadway, Room F-201 Sacramento, CA 95820	Office: Fax:	916-227-3777 916-227-3776
Santa Barbara Laboratory 820 Botello Road Goleta, CA 93127	Office: Fax:	805-681-2580 805-964-1034
Santa Rosa Laboratory 7505 Sonoma Highway Santa Rosa, CA 95409-6598	Office: Fax:	707-576-2415 707-576-2141

Appendix H

Chain of Custody Form

APPENDIX H

CHAIN OF CUSTODY FORM

CALIFORNIA COUNTY
Laboratory of Forensic Sciences

SEXUAL ASSAULT EVIDENCE COLLECTION KIT

FOR HOSPITAL PERSONNEL
(Please print)

☐ Female
☐ Male

Name of Patient:_____ Date of birth:_____
Last, First, Middle

Name of Examiner:_____

Name of Hospital:_____ Date of exam:_____

Law Enforcement Agency:_____

Agency Case No.:_____

AFFIX BIOHAZARD LABEL HERE AFTER SPECIMEN COLLECTION

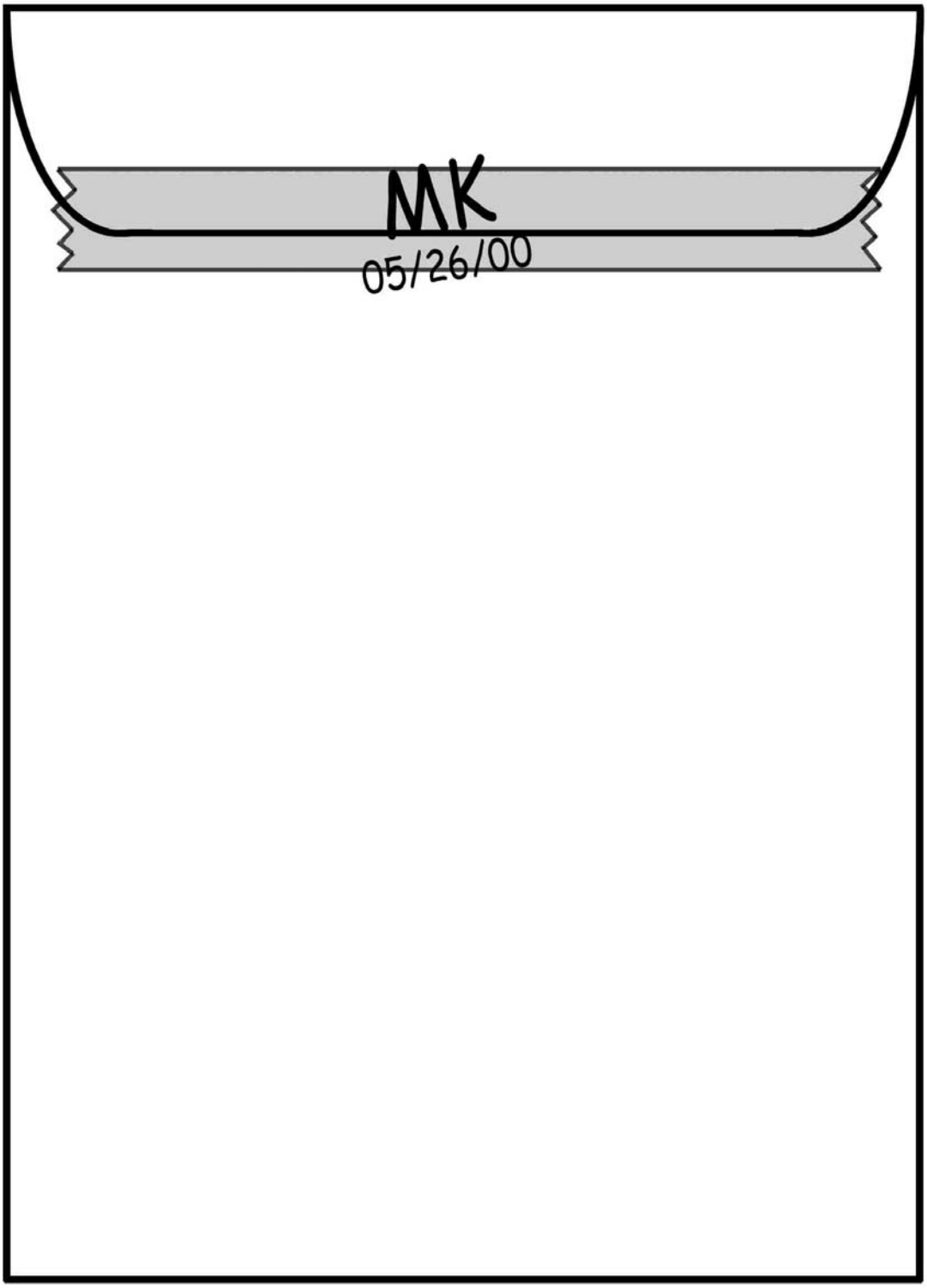
CHAIN OF CUSTODY

FROM: (Print Name and Sign)	TO: (Print Name and Sign)	DATE	TIME

Appendix I

Sealed Evidence Envelope

APPENDIX I
SEALED ENVIDENCE ENVELOPE



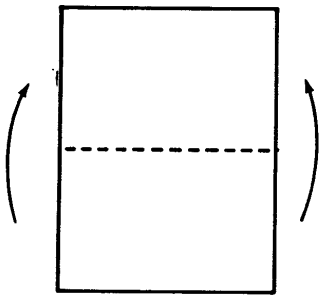
Note: Sign and date over the seal.

Appendix J

How to Make a Bindle

APPENDIX J

HOW TO MAKE A BINDLE



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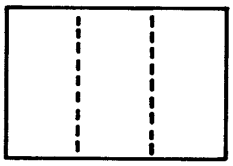

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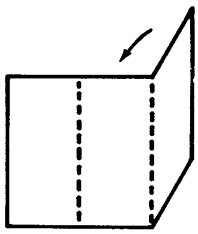
Fold the half-sized paper into thirds.



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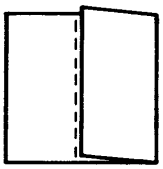

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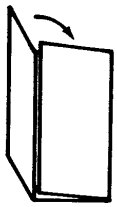

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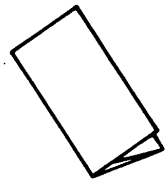


6

7

Fold in half. Seal the open end of the bindle, not the folded end. Initial the tape prior to sealing.

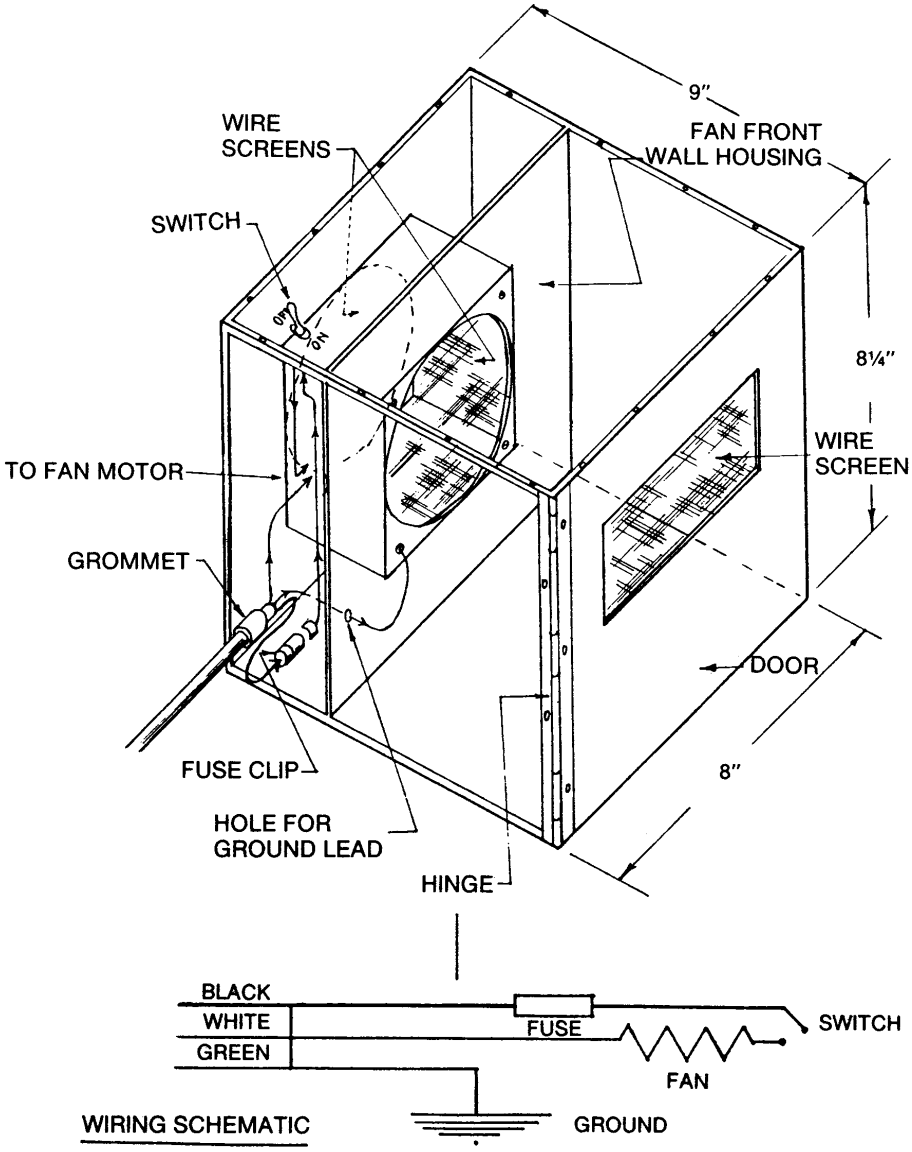
Appendix K

Specifications for Swab Drying Box

APPENDIX K

AIR DRYING BOX

(Not to scale)

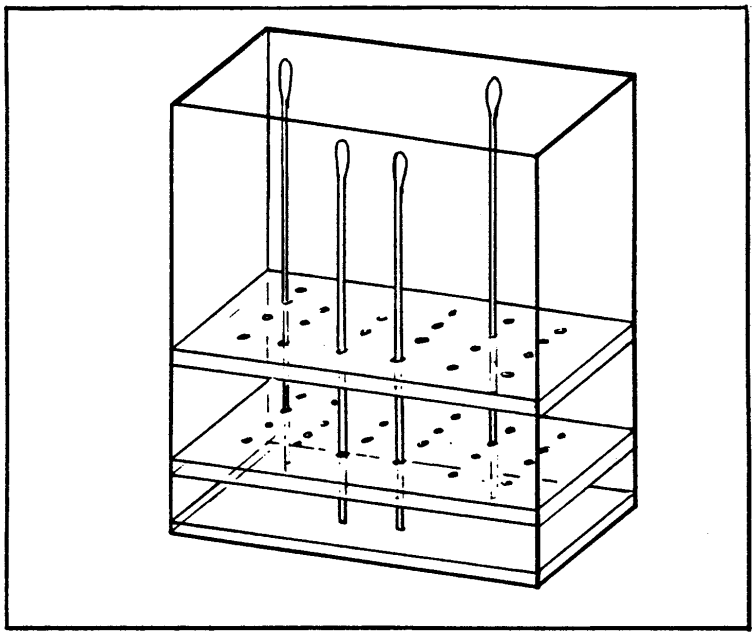


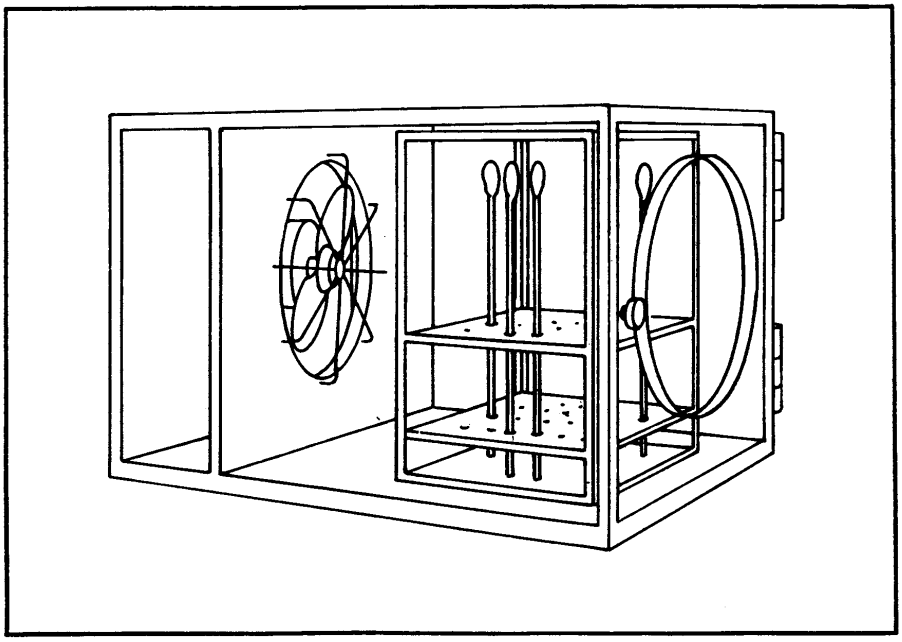
WIRING SCHEMATIC

APPENDIX K

SWAB RACK AND AIR DRYING BOX

(Not to scale)

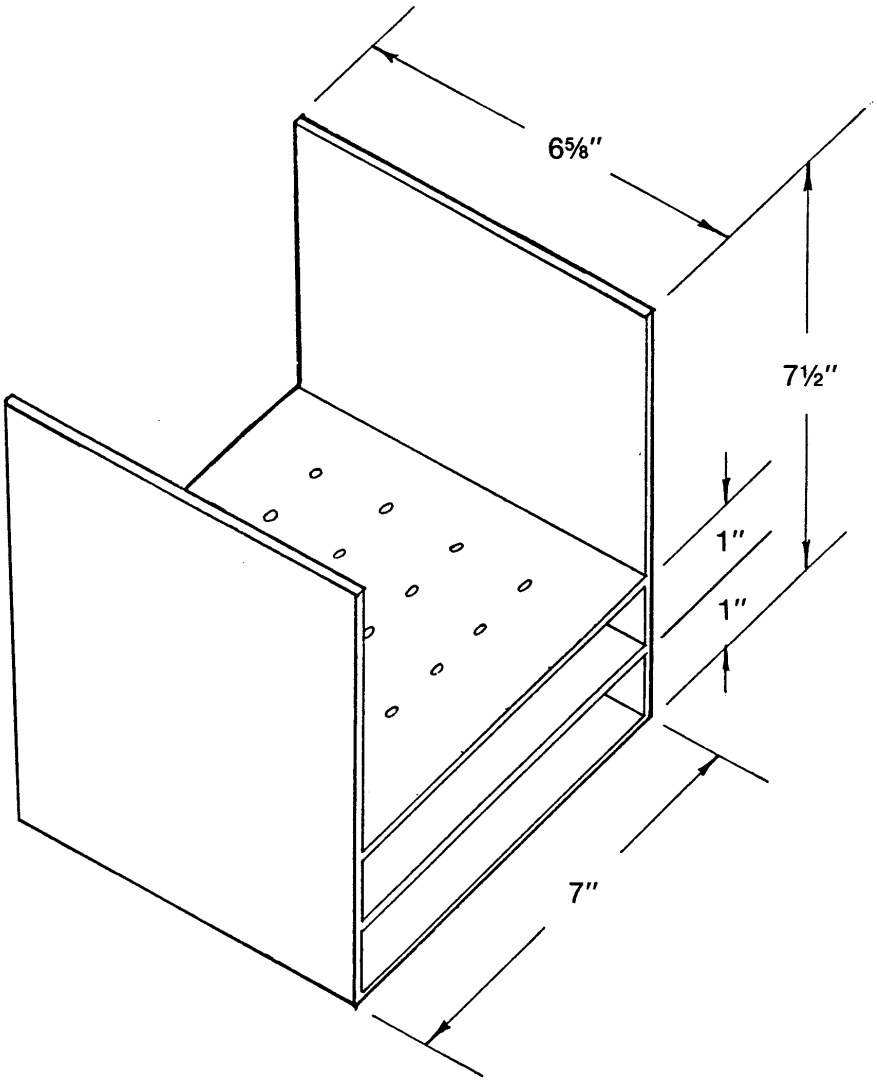




APPENDIX K

SWAB RACK

(Not to scale)



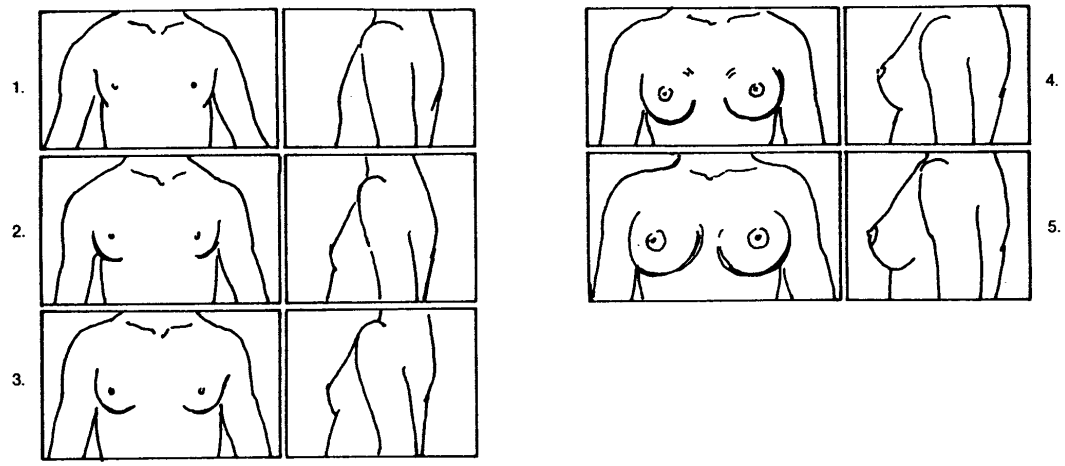
Appendix L

Tanner Stages

APPENDIX L

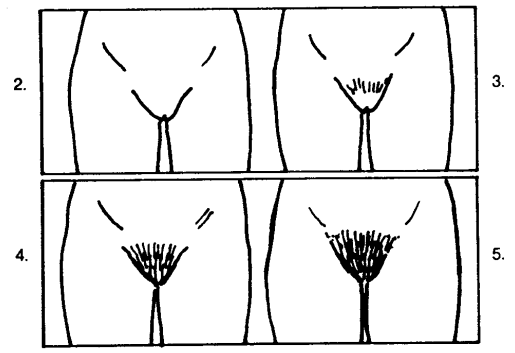
TANNER CLASSIFICATION OF SEXUAL MATURITY

BREASTS

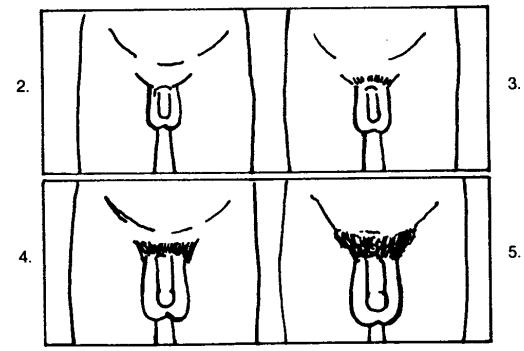


GENITAL/PUBIC

GIRLS — ADOLESCENT FEMALES



BOYS — ADOLESCENT MALES



Adapted from Tanner JM: Growth at Adolesence, Ed 2. Oxford, Blackwell Scientific Publications, 1962

Appendix M

APSAC Glossary of Terms and the Interpretation of Findings for Child Sexual Abuse Evidentiary Examinations

Appendix M

APSAC AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

PRACTICE GUIDELINES

GLOSSARY OF TERMS
AND THE
INTERPRETATION OF FINDINGS

FOR

CHILD SEXUAL ABUSE EVIDENTIARY EXAMINATIONS

This was published by the American Professional Society on the Abuse of Children (APSAC), the nation's largest interdisciplinary professional society for those who work in the field of child maltreatment. APSAC's aim is to ensure that everyone affected by child maltreatment receives the best possible professional response. APSAC provides ongoing professional education in the form of publications and conferences and, through the media and legislative advocacy, educates the public about the complex issues involved in child maltreatment. For further information contact:

APSAC at 407 Dearborn St., Suite 1300, Chicago, IL 60605
Phone: 312-554-0166 fax: 312-554-0919 E-mail: APSACPublis@aol.com

TABLE OF CONTENTS:

I. General terms:

Page

DEFINITION OF TERMS

I. General Terms/Definitions:

A. Abrasion
* An area of body surface denuded of skin or mucous membrane by some unusual or abnormal mechanical process. An injury.[1]

B. Colposcope
* An instrument with a light source and magnifying lens for direct observation and study of the tissues. May have a camera and/or other recording devices attached.[2,3,4]

C. "Clue cells"
* Vaginal epithelial cells with clusters of bacteria adhering to the surface. Associated with Bacterial Vaginosis, an over-growth of several organisms including Gardnerella vaginalis.[5,6,7,8]
* *A common finding in sexually active females.*[5,7]

D. Cunnilingus
* Oral stimulation of the female genitalia.[1]

E. Descriptive Terms

1. Anterior:
* Situated in front of or in the forward part of an organ, toward the head of the body; a term used in reference to the ventral or belly surface of the body.[1]

2. Posterior:
* Situated in back of, or in the back part of; a term used in reference to the back or dorsal surface of the body.[1]

3. Inferior:
* Situated below, or directly downward; a term used in reference to the lower surface of an organ or other structure.[1]

4. Superior:
* Situated above, or directly upward; a term used in reference to a structure occupying a position near the vertex.[1]

5. Cephalad:
* Toward the head; opposite caudad. [1]

6. Caudad:
* Directed toward the tail; opposite cephalad [1]

7. Dorsal:
* 1) Pertaining to the back. 2) denoting a position more to the back.[1]

8.	Ventral:	*	1) Pertaining to the belly. 2) denoting a position more toward the belly surface than some other object of reference; same as anterior in human anatomy.[1]
9.	Distal:	*	A term denoting the remoteness from the point of origin or attachment of an organ of part.[1]
10.	Proximal:	*	Nearest; closer to any point of reference: opposed to distal.[1]
11.	Peri:	*	A prefix meaning "around".[1]
12.	Clock position reference:	*	A method by which the location of a structure may be designated by using the numerals on the face of a clock. The 12 o'clock position is always superior (up). The 6 o'clock position is always inferior (down). *The position of a patient must be indicated when using this designation.*[9]
F.	Ecchymosis	*	A hemorrhagic area on the skin due to extravasation of blood into the skin or a mucous membrane.[1]
		*	A bruise.
G.	Elasticity	*	The state or quality of being distensible. Flexibility; adaptability.[1]
		•	Example: A hymen that changes its configuration with the different examination methods and/or positions. *An inexact term that should be avoided.*
H.	Erythema	*	A redness of the skin or mucous membranes produced by congestion (dilation) of the capillaries.[1] (Redness of tissues).
I.	Estrogenized:	*	Effect of influence by the female sex Hormone estrogen resulting in changes to the Genitalia.[1]
		*	The hymen takes on a thickened, redundant and pale appearance as the result of estrogenization. *These changes are observed in infants, with the onset of puberty, and as*

the result of exogenous estrogen.[1]

J. Examination methods:

1. Knee-chest Position Method (prone) * With the patient in a knee-chest position, the examiner places thumbs beneath the leading edge of the gluteus maximus and lifts while gently separating labia.[10-20]

2. Labial Separation * The labia majora are gently separated in a lateral and downward direction, exposing the vestibule.[10-17,20]

3. Labial Traction * The labia majora are grasped between the thumbs and index fingers and gently pulled toward the examiner. Usually performed in the supine position.[16,17,19,20,21,22]

K. Examination Positions:

1. Frog Leg Position * Examination position in which the patient lies in supine (lying on back, face upward) position with knees flexed and hips abducted. The bottoms of feet touch. [10-18]

2. Knee-chest Position (prone) * Examination position during which the patient rests on knees with the upper chest on the examination table in a lordotic ("sway-backed") posture. Elbows are flexed with hands placed on either side of the head.[1,10-18,20]

3. Knee-chest Position (supine) * Examination position during which the patient lies on his/her back with the hips flexed upon the abdomen.[13,16,19,20]

4. Lateral Decubitus (Recumbent) * Examination position in which the patients lies on side with the contra lateral thigh and knee drawn up; also called lateral recumbent position.

5. Lithotomy position * Examination position in which the patient lies on his/her back with his/her hips and

knees flexed and the thighs abducted and externally rotated.[1]

6. Prone Position
   * Examination position in which the patient lies face downward (on his/her abdomen).[1]

7. Supine Position
   * Examination position in which the patient lies (on his/her back) with their face upward.[1]

L. Fellatio
   * Oral stimulation or manipulation of the penis.[1]

M. Fordyce's Granule
   * Ectopic sebaceous glands found on the labia which present as yellowish white milia or papule.[1]

N. Friability
   * A term used to describe tissues that bleed easily, such as a labial adhesion when gently separated.

   * Friability of the posterior fourchette - A superficial breakdown of the skin in the posterior fourchette (commissure) when gentle traction is applied, causing slight bleeding.[9]

   • *A non-specific finding.*

O. Hemorrhoid
   * A varicose dilatation of a vein of the superior or inferior hemorrhoidal plexus, resulting from a persistent increase in venous pressure.[1]

P. Genitalia (External)
   * The external sexual organs, In males, includes the penis and scrotum. In females, includes the contents of the vulva.[1]

Q. Hyperemia
   * An excess of blood in a part; engorgement of the blood vessels.[1]

R. Hyperpigmentation
   * Increase in melanin pigment within tissues.[1]

   * *A common finding in darker skinned children. May be congenital in nature or caused by a past inflammatory response*.[23]

S.	Inflammation	*	A localized protective response of tissues, elicited by injury or destruction of tissues, which is usually characterized in the acute form by the classical signs of pain, heat, redness, swelling and loss of function.[4]
T.	"Intact hymen"	*	A term used in the past which implied a non-injured hymenal membrane.[11,24,25]
		*	***The use of this term is to be discouraged***.
U.	Intracrural intercourse (intralabial, dry or vulvar intercourse)	*	The act of rubbing the penis between the labia of the female without entering the vagina.[22,24-28]
V.	Laceration	*	A transection (cut) through the skin, mucous membranes or deeper structures of the body.[1]
		*	A tear through the full thickness of the skin or other tissue.[9]
W.	Leukocytes	*	White blood cells or corpuscles (pus) that are part of the inflammatory response to an infection.[1]
X.	Leukorrhea	*	A whitish, viscid (glutinous) discharge from the vagina and uterine cavity through the cervical os.[1]
		*	*A normal finding in adolescent and adult females. The term* ***physiologic discharge*** *is sometimes used instead.*[29,30]
Y.	Lichenification	*	Thickening of the skin markings, giving the skin a leathery appearance. Usually secondary to prolonged irritation secondary to rubbing, scratching or inflammation.[1,26]
Z.	Lichen Sclerosis et Atrophicus	*	A rare, chronic, atrophic skin disease characterized by homogeneous hypopigmented areas.[1,31-36]

		*	*It is the most common cause of kraurosis vulvae in females and balanitis xerotica obliterans in males.*[1]
		*	*May initially be confused with injuries resulting from a sexual assault.*[35,36]
AA.	"Marital introitus"	*	An enlarged hymenal orifice.
		*	***The use of this term is to be discouraged.***
BB.	Neovascularization	*	New blood vessel formation in abnormal tissue or in an abnormal location. Revascularization.[1]
		*	*A seldom used term due to the inability to verify.*[37]
		*	***The use of this term is to be discouraged.***
CC.	Pelvic inflammatory disease	*	Infection of the uterus, fallopian tubes and/or ovaries (Salpingo-oophoritis). Commonly called "PID".[1]
		*	*Usually caused by an ascending gonorrhea, chlamydia, aerobic or anaerobic bacterial infection.*[27,38]
DD.	Perineal Body	*	The central tendon of the perineum. Located between the vestibule and the anus in the female and between the scrotum and anus in the male.[9]
EE.	Petechiae	*	Small, pinhead sized hemorrhages caused by leaking capillaries. May be singular or multiple.[1]
		*	*Frequently caused by increased pressure within the blood vessel, as with straining during vomiting or with strangulation. May also be caused by a bleeding disorder, infection or localized trauma.*[1,28]
FF.	Scar	*	Fibrous tissue which replaces normal tissue after the healing of a wound.[9]
		*	*May be difficult to prove on clinical grounds, such as during visual inspection or palpation alone.*

GG.	Sodomy	*	In medical usage, this term is restricted to anal intercourse.[1]
HH.	Straddle Injury	*	An injury to the perineum when the individual falls on an object while the legs are spread apart.[1,41]
II.	Synechiae	*	Any adhesion which binds two anatomic structures through the formation of a band of fibrous or scar tissue.[1,9]
JJ.	Tanner Scale of Secondary Sexual Development	*	A sexual maturity rating scale that defines the stage of puberty by physical evidence of breast development and pubic hair in the female. The testicular/scrotal and penile size plus the location and type of pubic hair are used in the male. Stages range from Stage I (prepubertal child) to Stage V (fully mature adult).[40]
KK.	Transection	*	A cutting across. Division by cutting or tearing transversely.[1]
	(Complete Hymenal)	*	A tear or laceration through the entire width of the hymenal membrane extending to its attachments to the vaginal wall.[9]
	(Partial Hymenal)	*	A tear or laceration through a portion of the hymenal membrane not extending to its attachment to the vaginal wall.[9]
		*	*The strict definition of the term "transection" implies a complete tear through the entire width of a membrane.* ***Therefore, the use of the term "partial transection" is to be discouraged****. The term partial tear is suggested*.
LL.	Vascularity (Increased or Prominent)	*	Dilation of existing superficial blood vessels.[9]
MM.	Vulvar Coitus (Intralabial or Intracrural Intercourse)	*	Rubbing of the penis between the labia of the female without entering the vagina.[26,41,42]

II. Female:

A. Mons Pubis

* The rounded fleshy prominence, created by the underlying fat pad, which lies over the symphysis pubis (pubic bone) in the female.[9]

B. Perineum

* The external surface or base of the perineal body, lying between the vulva and the anus in the female. Underlying the external surface of the perineum is the floor and its associated structures occupying the pelvic outlet which is bounded anteriorly by pubic symphysis (pubic bone), laterally by the ischial tuberosities (pelvic bones) and posteriorly by the coccyx (tail bone).[1,9]

C. Vulva

* The external genitalia or pudendum of the female. Includes the mons pubis, clitoris, labia majora, labia minora, vaginal vestibule, urethral orifice, vaginal orifice, hymen, and posterior fourchette (or commissure) [25,45]

1. Vulvitis

* Inflammation of the labia and vestibule.[1]

* *May be caused by a variety of irritants, such as, but not limited to improper wiping techniques, poor hygiene, bubble bath, shampoo or infectious agents.*[44-47]

2. Vulvar coitus

* Rubbing of the penis between the labia of the female without entering the vagina.[26,41,42]

D. Clitoris/Clitoral Hood

1. Clitoris

* A small cylindric, erectile body, situated at the anterior (superior) portion of the of the vulva, covered by a sheath of skin called the clitoral hood; homologous with the penis in the male.[1,9,43]

2. Clitoral Hood

* The skin covering the clitoris. Homologous with the prepuce (foreskin) in the male.[1]

* May become erythematous and edematous from contact with a variety of irritants or from trauma.[44-47]

E. Labia

1. Labia Majora (Outer Lips)
   * Rounded folds of skin forming the lateral boundaries of the vulva.[9,43]

2. Labia Minora (Inner Lips)
   * Longitudinal, thin folds of tissue within the labia majora. In the prepubertal child, these folds extend from the clitoral hood to approximately the midpoint on the lateral wall of the vestibule. In the adult, they enclose the vestibule and contain the opening to the vagina.[9,43]
   * *Commonly injured in accidental straddle injuries.*[48-50]

3. Labial Adhesion (Agglutination)
   * The result of adherence (fusion) of the adjacent, outer-most, mucosal surfaces of the posterior portion vestibular walls. This may occur at any point along the length of the vestibule although it most commonly occurs posteriorly (inferiorly).[9,51,52]
   * *A common finding in infants and young children. Unusual to appear for the first time after 6 to 7 years of age. May be related to chronic irritation.*[53-55]

F. Vestibule (Vaginal)
   * An anatomical cavity containing the openings of the vagina, the urethra and the ducts of Bartholin's glands. Bordered by the clitoris anteriorly, the labia on the sides and the posterior commissure (fourchette) posteriorly (inferiorly). The vestibule encompasses the fossa navicularis immediately posterior (inferior) to the vaginal introitus.[1,9,43]

1. Anterior Commissure
   * The union of the two labia minora anteriorly (toward the clitoris). [9,43]
   * *May be torn as a result of a straddle injury or by forceful separation of the labia minora.*[50]

2. Erythema

* A redness of the skin or mucous membrane produced by congestion or dilatation of the capillaries.[1] Redness of tissues.[9]

* *A non-specific finding caused by local irritants, inflammation, infections or trauma.*[44-47]

3. Urethra

* The membranous canal which conveys urine from the bladder to the exterior of the body.[1]

a) Urethral Dilatation

* An enlargement of the urethral meatal aperture.

* *A normal variant when labial traction examination technique is employed.*[16,56]

b) Urethral Meatus

* External opening of the canal (urethra) from the bladder.[1]

c) Urethral Prolapse

* Evagination of the lining of the urethra.[1]

* *May present as bleeding from the female genitalia. Most commonly occurs in African/American children.*[57,58]

* *Relationship to sexual abuse has not yet been determined.*

d) Urethritis

* Inflammation of the urethra.[1]

* *May be caused by a variety of irritants (such as bubble bath) and infections.*[44-47]

4. Periurethral

* Pertaining to tissue surrounding the urethral meatus.[1]

a) Periurethral Bands (Pubo-urethral Bands)

* Small bands, lateral to the urethra, that connect the periurethral tissues to the wall of the vestibule. These bands are usually symmetrical and frequently create a semi-lunar shaped space between the bands on either side of the urethral meatus. Also called urethral support ligaments.[4,56,59-63]

* *Found in the majority of females and accentuated when the labial traction examination technique is used.* [16,56,59,60]

5.	Hymenal Orifice	*	The opening to the vagina through the hymenal membrane.[43]
6.	Perihymenal	*	Pertaining to tissues surrounding the hymen.[1]
	a) Perihymenal Bands (Pubo-vaginal)	*	Small bands of tissue, lateral to the hymen, that form a connection between the perihymenal structures and the wall of the vestibule.[4,56,59-63]
		*	*A less frequently observed finding than periurethral bands in prepubertal girls. Accentuated when the labial traction examination method is used.*[16,56,59-63]
		*	*Usually a congenital variation. Rarely caused by trauma*[53,54,59]
7.	Vaginal Introitus (Sphincter vaginae)	*	The pubovaginalis muscle that forms the entrance to the vagina. The muscular bulbospongiosus in the female.[1]
8.	Follicles	*	Small (1-2 mm) clear or yellow colored papules on the hymen and/or surrounding tissues that appear to contain lymph-like material.[4,56,62]
		*	*Etiology is uncertain*.
9.	Fossa Navicularis	*	Concavity of the lower part of the vestibule situated posterior (inferior) to the vaginal orifice and extending to the posterior fourchette (posterior commissure).[9,43]
		*	*May be injured as a result of a straddle injury or a sexual assault.*[39,48-52]

a) Asymmetry of Fossa Navicularis: (Puborectal Bands)

* The posterior commissure attachment of labia minora joins the fossa at different levels creating an asymmetrical appearance and occasionally a band-like configuration.[56]

* *A relatively common finding of no significance.*[56]

b) Linea Vestibularis (Midline sparing)

* A vertical, pale/avascular line across the posterior fourchette and/or fossa navicularis, which may be accentuated by putting lateral traction on the labia majora.[9,13,56,59,65,66]

* *A common finding that is found in girls of all ages including newborns and adolescents.*[59,65,66]

10. Posterior Commissure:

* The union of the two labia posteriorly (toward the anus).[9]

* The junction of two labia minora posteriorly (inferiorly). This area is referred to as a posterior commissure in the prepubertal child. In children, the labia minora are not completely developed and do not connect inferiorly until puberty. In the postpubertal female, it is referred to as the posterior fourchette.[9]

* *May be injured as the result of a straddle injury or during a sexual assault.*[39,50,67]

G. Hymen

* A membrane which partially or rarely, completely covers the external vaginal orifice. Located at the junction of the vestibular floor and the vaginal canal.[1,9,68-72]

The external surface is lined with highly differentiated squamous epithelium with loose cornification. The internal surface is lined with vaginal epithelium. Origin is the external vaginal plate of the urogenital sinus.[68]

			Wide anatomic variation in types: annular, crescentic, fimbriated (denticular), septate, cribriform, imperforate.[13,14,15,56,59,62,63,68,69]
			Wide variation in character of membrane: redundant/thick vs. smooth/thin (velamentous) depending upon age and stage of secondary sexual development.[13,14,15,56,59,62,63,68,69]
			All females with a normal Mullerian system and normal external genitalia have this structure.[59]
1.	Angularity of Hymen	*	Relatively sharp angles in the contour of the hymenal inner edge.[64,75]
		*	*When finding is located on the posterior hymenal rim and persists during multiple examination techniques it may be evidence of hymenal trauma.*[64,75,76,77]
2.	Annular (Circumferential)	*	The hymenal membrane extends completely around the circumference of the vaginal orifice.[9]
		*	*The most common configuration in the newborn and young infant.*[59,69,72,78]
3.	Anterior (Superior) Hymenal Wings (Flaps)	*	Bilateral projections of tissue on the anterior (superior) edge of the hymen.[79]
		*	*A common finding in infants and children less than five years of age as well as during the onset of puberty. A normal physiologic tissue response to estrogens.*[79]
4.	Attenuated Hymen	*	The term has been used to describe areas where the hymen is narrow.[76,77,90]
		*	*The term should be restricted to indicate a documented change in the width of the posterior portion of the hymen following an injury*[9]
5.	Caruncula Myrtiformis (Hymenales)	*	Small elevations of rounded mounds of hymen encircling the vaginal orifice.[1]

		*	*Found in sexually active and postpartum females.*[1,2,80]
6.	Cleft/notch	*	An angular or "V"-shaped indentation on the edge of the hymenal membrane. May extend to the muscular attachment of the hymen.[2,4,75]
		*	*A relatively sharp, "V"-shaped notch or cleft, that persists during multiple examination techniques may be evidence of hymenal trauma.*[64,75]
7.	Cleft (Anterior)	*	A shallow indentation of the hymenal membrane that does not extend to the attachment of an annular hymen. [59,60]
		☝	*Girls with a crescent shaped hymen appear to have an absence of the membrane between the 11 and 1 o'clock positions. In this situation the term "anterior sparing" is preferable. Newborns frequently have a cleft or notch in the midline of the hymen superiorly. This may be the antecedent of the crescent shaped hymen.*[56,69,81]
8.	Cleft (Lateral)	*	An indentation along the lateral (2 to 4 and 8 to 10 o'clock positions with the child supine) margins of the hymen.[1,59,63]
		*	*Must be interpreted with caution, particularly if there are bilateral, smooth edged, symmetrical clefts, which may represent naturally occurring variations. May be found in sexually active females.*[56,59,63,76,80]
9.	Clefts (Posterior)	*	An indentation in the posterior (4 to 8 o'clock positions with the child supine) edge of the hymen. [2,17,25,50,64,82]
		*	*Clefts in the posterior rim, that persist during multiple examination techniques are usually evidence of hymenal trauma.*[59,61,64,65,75,76]
10.	Concavity (Depression)	*	A curved or hollowed "U"-shaped depression on the edge of the hymenal membrane.[1]

11.	Cribriform	*	A hymen with multiple openings.[9,43]
		*	*A congenital variant.*[9,43]
12.	Crescentic	*	Hymen with anterior attachments at approximately the 11 o'clock and the 1 o'clock positions with no hymenal tissue visible between the two attachments. [9,17,56,59,69]
		*	*The most common hymenal configuration in the school aged, prepubertal child.*[56,60]
13.	Cyst (Hymenal)	*	A fluid filled sac of tissue confined within the hymenal tissue. [1,9,63,83]
		*	*Considered to be a normal variant.*[63,83]
14.	Erythema of the Hymen	*	A redness of the hymenal membrane produced by congestion [engorgement] of the capillaries.[1]
		*	*A non-specific finding. May result from a variety of irritants as well as direct trauma.*[44,45,46,47,63]
15.	External Hymenal Ridge	*	A midline, longitudinal ridge of tissue on the external surface of the hymen. May be either anterior or posterior. Usually extends to edge of the membrane.[9,59,63]
		*	*A congenital variant most commonly found during the newborn period or infancy.*[59,63]
16.	Fimbriated/ Denticular	*	Hymen with multiple projections or indentations along the edge, creating a ruffled appearance.[1]
		*	*A congenital variant.*[69]
17.	Hymenal Orifice	*	The opening in the hymenal membrane which constitutes the entrance or outlet of the vagina.[1]
18.	Hymenal Orifice's Diameter	*	The distance from one edge of the hymen to the opposite edge of the hymenal orifice. The most common measurement used is the horizontal (lateral) diameter.[14,16,84,85]

		*	*Hymenal orifice size varies with the age of the child, the examination technique and other factors such as the state of relaxation.*[16,56,86]
		*	***Size of the hymenal orifice should be used with caution in determining if prior sexual abuse has occurred***.
19.	Imperforate	*	A hymenal membrane with no opening.[9]
		*	*An uncommon congenital variant.*[56]
20.	Inflammation (Hymenal)	*	A localized protective response elicited by injury or destruction of tissues.[1]
		*	*A non-specific finding that can result from a variety of causes including trauma.*[44-47]
21.	Irregular Hymenal Edge	*	A disruption in the smooth contour of the hymen.[64,75,87,88]
		*	*A general descriptive term requiring further definition.*
22.	Key-Hole Configuration	*	A "Key-hole" appearance of the hymenal orifice is created when the posterior-lateral portions of the hymenal membrane project into the orifice creating a concavity inferiorly.[4]
		*	*A descriptive term that may be misinterpreted.* ***Recommend avoidance***.
23.	Laceration of the Hymen (Acute Transection)	*	An injury or tear of the hymenal membrane that is usually associated with a blunt force penetration.[64,75,82]
24.	Mound (Bump)	*	A solid, localized, rounded and thickened area of tissue on the edge of the hymen.[9]
		*	*May be created by the hymenal attachment of a longitudinal intravaginal ridge (LIR).*[56,59,60,61]
25.	Narrow Hymenal Membrane (Rim)		

	(Attenuated)	*	The term used to describe the width of the hymenal membrane as viewed in the coronal plane, i.e. from the edge of the hymen to the muscular portion of the vaginal introitus (opening).[9]
		*	*An abnormally narrow hymenal membrane may be evidence of prior trauma.*[4,15,64,76,82,90,91,92]
26.	Notch/cleft (Hymenal)	*	An angular or "V" shaped indentation on the edge of the hymenal membrane.[1] May extend to the muscular attachment of the hymen.
		*	*A relatively sharp, "V"-shaped notch or cleft, that persists during multiple examination techniques may be evidence of hymenal trauma.*[59,61,64,65,75,76]
27.	Perihymenal	*	Pertaining to tissues surrounding the hymen.[1]
28.	Perihymenal Bands (Pubo-vaginal)	*	Bands of tissue, lateral to the hymen, that form a connection between the perihymenal structures and the wall of the vestibule.[9]
		*	*A less frequently observed finding than periurethral bands.*
		*	*Accentuated when the labial traction examination method is used.*[16,56,59-63]
		*	*Usually a congenital variant. Rarely caused by trauma.*[53,56,59]
29.	Redundant Hymen	*	Abundant hymenal tissue which tends to fold back upon itself or protrude [9]
		*	*A common finding in females whose hymenal membranes are under the influence of estrogen (Both infants and adolescents).*[56,59,62,76]
30.	Rolled Edges	*	The edge (border) of the hymen which tends to roll in-ward or outward upon itself. May unfold through the use of the knee-chest position, application of water, through manipulation with a moistened Q-tip or other techniques.[37,16,17,62,76,77,90]

		*	*A normal variant most commonly noted in prepubertal children.*[16,56]
31.	Rounded Edges	*	Hymenal edges that appear thick and rounded and do not thin out with the different examination techniques, the application of water or other maneuvers used to unroll an elastic, redundant hymen.[37,56]
		*	*May be the result of hormonal influence, poor relaxation, an inflammatory reaction, the attachment of an underlying intravaginal longitudinal ridge or past injury.*[17,37,56,62,76,77,90]
32.	Scalloped Edges	*	A series of rounded projections along the edge of the hymen.[62]
		*	*A common finding in early adolescence.*[79]
32.	Septal Remnant (Hymen Subseptus)	*	A small appendage (tag) attached to the edge of the hymen. Commonly located in the midline on the posterior rim. Frequently associated with a concomitant thickened ridge on the hymen which extends from the appendage (septal remnant) to the muscular attachment of the vaginal introitus. May be associated with similar appendage on opposite side of hymenal orifice. (Similar to hymenal tags.)[56]
		*	*Considered to be a normal variant.*[56,59,81]
		*	*A diagnosis by implication unless an intact septum was previously seen*.
33.	Septated Hymen	*	A hymen with band(s) of tissue, which bisects the orifice creating two or more openings.[9,62,63,69,76,78,81,92,93,94,95,96]
		*	*A congenital variant.*[59,78,81,95,96]
35.	Tag (Hymenal)	*	An elongated projection of tissue arising from any location on the hymenal rim. Commonly found in the midline and may be an extension of a posterior vaginal ridge.[9]
		*	*Usually a congenital variant. Rarely caused by trauma.*[59,63,93,94]

36. Thickened edge

* A term used to describe the relative amount of tissue between the internal and external surfaces of the hymenal membrane.[9]

* *May be the result of hormonal influence, poor relaxation, the attachment of an underlying intravaginal longitudinal ridge or past injury.*[37,56,59,60.61,63]

37. Transection of hymen (complete)

* A tear or laceration through the entire width of the hymenal membrane, extending to (or through) its attachment to the vaginal wall.[9]

38. Transection of hymen (partial)

* A tear or laceration through a portion of the hymenal membrane, <u>not</u> extending to its attachment to the vaginal wall.[9]

* *The strict definition of the term "transection" implies a complete tear through the entire width of a membrane.*
*Therefore, the use of the term "**<u>partial transection</u>**" is to be discouraged. The term <u>partial tear</u> is suggested.*

H. Posterior Fourchette

* The junction of two labia minora posteriorly (inferiorly). This area is referred to as a posterior commissure in the prepubertal child. In children, the labia minora are not completely developed and do not connect inferiorly until puberty. In the postpubertal female, it is referred to as the posterior fourchette.[9]

1. Friability

* A superficial breakdown of the skin of the posterior commissure when gentle traction is applied, causing a slight bleeding.[9]

- *Considered to be a non-specific finding.*

	2.	Linea Vestibularis (Midline sparing)	*	A vertical, pale/avascular appearing line across the posterior fourchette and/or fossa navicularis, which may be accentuated by putting lateral traction on the labia majora.[9,56,65,66]
			*	*A common finding that is found in girls of all ages, including newborns and adolescents.*[56,59,65,66]
	3.	Median (Perineal) Raphe	*	A ridge or furrow that marks the line of union of the two halves of the perineum.[1,9,97]
	4.	Midline Commissure	*	The site of union of corresponding parts. i.e. anterior or posterior commissure of the labia minora.[1]
	5.	Perineal Groove	*	Developmental anomaly, also called "Failure of Fusion". A midline defect in the median raphe in which the skin and/or mucosal surfaces fail to fuse. May involve any part of the median raphe, from the fossa to the anus.[9,39]
	6.	Posterior Commissure	*	The union of the labia minora posteriorly (inferiorly). Forms the posterior fourchette.[9]
I.	Vagina		*	The uterovaginal (genital) canal in the female. This internal structure extends from the uterine cervix to the inner aspect of the hymen.[9]
	1.	Intravaginal Columns (columnae rugarum vaginae)	*	Raised (sagittally oriented) columns most prominent on the anterior wall with less prominence on the posterior wall.[9]
	2.	Intravaginal Longitudinal Ridges (ILR)	*	Narrow, mucosa-covered ridges of tissue on the vaginal wall that may be attached to the inner surface of the hymen. They may be located in all four quadrants and are usually multiple in number.[56,59,63]

		*	*A normal finding.*[56,59,63]
3.	Posterior Fornix	*	A cavity within the vagina and located posteriorly (inferior) to the cervix.[1]
4.	Rugae (Vaginal)	*	Folds of epithelium (rugae) running circumferentially from the vaginal columns.[9]
		*	*A normal finding.*[56]
5.	Vaginal Introitus	*	The pubovaginalis muscle which forms the entrance to the vagina.
		*	*Frequently used synonymously with hymenal orifice*.
6.	Vaginitis	*	Inflammation of the vagina; it may be marked by a purulent discharge and discomfort.[1]
		*	*May be caused by a variety of conditions, including bacterial vaginosis, sexually transmitted diseases, foreign bodies, to name a few*.[44,45,46,47,99,100,101,102,103]

3. Male:

A.	Balanitis	*	Inflammation of the glans penis; it is usually associated with phimosis.[1]
		☝	*Usually a non-specific finding.*
B.	Corona of glans penis	*	The rounded proximal border of the glans penis, separated from the corpora cavernosa penis by the neck of the glans.[1]
C.	Frenulum	*A small fold of mucus membrane that attaches the prepuce to the ventral surface of the penis.[1]	
D.	Glans penis	*	The cap-shaped expansion of the corpus spongiosum at the end (head) of the penis; also called balanus. It is covered by a mucus membrane and sheathed by the prepuce (Foreskin) in the uncircumcised male.[1,9]
E.	Median (Perineal) raphe	*	A ridge or furrow that marks the line of union of the two halves of the perineum.[1,9]
F.	Paraphimosis	*	Retraction of the phimotic foreskin, causing a painful swelling of the glans that, if severe, may cause dry gangrene unless corrected.[1]
G.	Penis	*	Male sex organ composed of erectile tissue through which the urethra passes. Homologous with the clitoris in the female.[1,9]
		*	*The penis is rarely injured as the result of sexually motivated abuse.*[104-108]
H.	Phimosis	*	Constriction of the preputial orifice which limits the retraction of the prepuce (foreskin) back over the glans.[1]
I.	Posthitis	*	Inflammation of the prepuce (foreskin).[1]
J.	Prepuce (Foreskin)	*	A covering fold of skin over the glans of the penis. (preputium penis).[1]
K.	Prostate	*	Gland in the male which contributes to the seminal fluid and accounts for the liquefaction of the coagulated semen. Fluid contains acid phosphatase, citric acid and proteolytic enzymes.[1]
L.	Scrotum	*	The pouch which contains the testicles and their accessory organs.[1,9]

M. Testes

* Male sex organs (gonads) which produce spermatozoa and testosterone.[1]

N. Urethra

* The membranous canal which conveys urine from the bladder to the exterior of the body.[1]

1. Urethral meatus (orifice)

* The external opening of the canal leading from the bladder.[1]

2. Urethritis

* Inflammation of the urethra.[1]

- *Usually a non-specific finding, however, may be caused by a sexually transmitted disease.*

O. Vas Deferens

* The excretory duct of the testicle, passing from the testis to the ejaculatory duct.[1]

4. Anal:

A. Anal Dilation (dilatation)

* Opening of the anus secondary to relaxation of the external (and possibly the internal) anal sphincter muscles with minimal traction on the buttocks.[9]

* *A finding that must be interpreted with caution.*

* *Anal dilatation has been observed in both abused and non-abused children. It is associated with a variety of causes including sedation, anesthesia and trauma. It is a common post mortem finding.*[23,28,82,87,106,109,110,111,112]

* *Anal dilation that occurs within 30 seconds, is greater than 20mm in the A-P diameter with no stool present in the rectal ampulla has been associated with prior anal trauma.*[23,28,39,42,62,77,106,107,112]

B. Anal Fissure

* A superficial break (split) in the perianal skin which radiates out from the anal orifice.[9]

* *A variety of causes including the passage of hard stools (constipation), diseases such as Crohn's Disease and trauma.*[37,39,68,106,109,111,112]

C. Anal Laxity

* Decrease in muscle tone of the anal sphincters resulting in dilation of the anus.[23,28,106,109,117]

* *May occur immediately following an acute/forced sodomy.*[28,42,106,109,111]

D. Anal Skin Tag

* A protrusion of anal verge tissue which interrupts the symmetry of the perianal skin folds.[9] A projection of tissue on the perianal skin.

* *When located outside the midline, causes other than a congenital variation should be considered, including such things as Crohn's disease or trauma.*[42,77,82,106,107,109,115,120,121]

E. Anal Spasm

* An involuntary contraction of the anal sphincter muscles. May be attended by pain and interference with function.[1]

		*	*May be found immediately post assault.*[42,62,107]
F.	Anal Verge	*	The tissue overlying the subcutaneous external anal sphincter at the most distal portion of the anal canal (anoderm) and extends exteriorly to the margin of the anal skin.[9,94,121]
G.	"Anal Wink"	*	Reflex anal sphincter muscle contraction as a result of stroking the perianal skin. Used to determine sensory nerve function.[37,111,112]
		*	*Relationship to sexual abuse is unknown*.
H.	Anus	*	The anal orifice, which is the lower opening of the digestive tract, lying in the fold between the buttocks.[1,9]
I.	Diastasis Ani (Smooth Area)	*	A smooth, often "V" or wedge shaped area at either the 6 or 12 o'clock positions in the perianal region. It is due to the absence of the underlying corrugator external anal sphincter muscle and results in a loss of the usual anal skin folds in the area.[4,9,23,41]
		*	*A congenital variant.*[23,39]
J.	Ecchymosis of the Perianal Tissues	*	A hemorrhagic area (bruise) on the skin or mucous membrane of the perianal tissues due to extravasation of blood most commonly caused by external trauma.[1]
		*	*May be confused with venous congestion and postmortem lividity.*[23,118]
K.	Edema (Swelling)	*	The presence of abnormal amounts of fluid in the intercellular space.[1]
		*	*If secondary to trauma, it will usually be accompanied by erythema, pain and swelling of perianal skin folds.*[1,28,109]
L.	Erythema (Perianal) *		Perianal erythema: A redness of the skin or mucous membranes due to congestion of the capillaries.[1]
		*	*A non-specific finding that may result from a variety of causes including, improper hygiene, infection or trauma.*[23,106,109]

M.	Fistula in Ano	*	Perianal fistulas resulting from developmental abnormalities of the mucosal glands at the base of the anal crypts. Usually manifests as a draining pustule in the first year of life. More common in males (4:1)[121]
N.	Flattened Anal Skin Folds	*	A reduction or absence of the perianal folds or wrinkles, noted when the external anal sphincter is partially or completely relaxed.[9]
		*	*The relationship to sexual abuse is unknown. A common finding in sedated, relaxed children and at autopsy.*[23,82,112]
O.	Funnel Appearance	*	A decrease in the fatty (subcutaneous) tissue surrounding the anus, leading to a concave appearance.[111,112]
		*	*Relationship to sexual abuse is unknown.*
P.	Hemorrhoid	*	A varicose dilatation of a vein of the superior or inferior hemorrhoidal plexus, resulting from a persistent increase in venous pressure.[1]
Q.	Hyperpigmentation	*	Increase in melanin pigment within the perianal tissues.[1]
		*	*A common congenital finding in darker skinned children. May be associated with post-inflammatory changes.*[23,106]
R.	Intermittent anal dilation	*	Anus dilates intermittently during examination, particularly in the prone knee-chest position.
		*	*A common finding in children of all ages.*[23,112]
S.	Lacerations (Perianal)	*	A tear in the tissues immediately surrounding the anus.
		*	*May result from a variety of causes including the passage of hard stools and the insertion of foreign objects, including a penis.*[68,82,106,109,112,115]
		*	*Failure of fusion of the median raphe may simulate a laceration.*[120]

T. Pectinate Line (Dentate line)

* The saw-toothed line of demarcation between the distal (lower) portion of the anal valves and the pecten, a smooth zone of simple stratified epithelium which extends to the anal verge.[1]

* *The pectinate line only appears when the external and internal anal sphincters relax and the anus dilates. A common finding at autopsy.*[9,113]

U. Perianal Skin Folds

* Wrinkles or folds of perianal skin radiating from the anus, which are created by the contraction of the external anal sphincter.[9]

V. Perianal Venous Congestion

* The collection of venous blood in the venous plexus of the peri-anal tissues creating a <u>flat</u>, purple discoloration. May be localized or diffuse.[23]

* *A common finding in children when the thighs are flexed upon the hips for an extended period of time.*[23]

W. Perianal Venous Engorgement (Pooling)

* Pooling of venous blood in the perianal tissues creating a bluish-purple <u>bulging</u> of the tissues. May be localized or diffuse.

* *Significance is currently unknown.*

X. Rectum

* The distal portion of the large intestine, beginning anterior to the third sacral vertebra as a continuation of the sigmoid and ending at the anal canal.[1]

* Terminal (lower) end of the intestinal tract (colon).[1]

Y. Reflex Anal Dilatation

* Anal dilation which occurs upon stroking the buttocks.[111,114]

* *Once considered to be evidence of prior sexual abuse. Relationship to sexual abuse is currently unclear.*[28,39,111,112]

		*	*Refer to anal dilation and anal wink.*
Z.	Scars of Perianal Tissues	*	Scar formation in the tissues immediately surrounding the anus.
		*	*While scar formation is usually a result of prior trauma it is an uncommon finding. Injured perianal tissues heal rapidly and leave little evidence of prior trauma.*[82,109]
		*	*Diastasis ani, a congenital variation, may be confused with scar formation.*[39]
AA.	Shallow Anal Canal	*	Relaxation of the anal sphincter muscles causing a flattening of the anal verge that may lead to exposure of the pectinate line and the anal canal.
		*	*A common finding during anesthesia, following sedation and at autopsy.*[79,82,113]
		*	*Relationship to sexual abuse is unknown.*
BB.	Tag (Anal)	*	A protrusion of anal verge tissue which interrupts the symmetry of the perianal skin folds.[9]
		*	*Perianal skin tags outside the midline may be evidence of prior trauma.*[41,82,106,107,109,121]

5. Infections of the Uro-genital Tract:

A. Bacterial Vaginosis:

* Altered vaginal flora resulting in a malodorous discharge. *Gardnerella vaginalis, Bacteroides, Mobiluncus* and *Peptococcus* species have been found in increased numbers in this condition. Characterized by 1) Increase in the pH; 2) Malodorous discharge; 3) Abnormal flora; 4) Positive "whiff test" (i.e. the release of a “fishy”, amine odor upon the addition of KOH to a drop of vaginal fluid) and; 5) Clue cells.

* *A common finding in sexually active adults and adolescents. Relationship to sexual abuse in prepubertal females is unclear.*[5,6,7,8,123,124,125]

B. Candidiasis

* Yeast (moniliasis) infection caused by Candida species.[1]

* *A common cause of "diaper dermatitis" in infants. An uncommon vaginal infection in prepubertal children.*[5,121]

* *A common vaginal infection in adolescents and adult females.*[5,121]

C. Chlamydia Trachomatis:

* A sexually transmitted organism. May be transmitted to newborns during the birth process and carried in an asymptomatic state.[37,121,124,126,-134]

D. Condylomata Acuminata

* Venereal warts caused by human papilloma virus. A sexually transmitted disease in adults. May be transmitted to newborns during the birth process.[135-141]

* *Children with condyloma acuminata should be evaluated for the possibility of sexual abuse.*[135,137,142]

E. Gardnerella Vaginalis

*A bacterium commonly found in sexually active females and associated with bacterial vaginosis.[94,123]

F.	Genital Mycoplasma	*	A common organism found in sexually active females.[5,6,7,8]
G.	Gonorrhea	*	Infection due to a gram negative, intracellular diplococcus *Neisseria gonorrhoeae*.[1]
		*	*A sexually transmitted disease in most cases. May be transmitted to newborns during the birth process.*[94,121,143-146]
H.	Hepatitis B	*	A viral infection with multiple modes of transmission. It may be acquired during the birth process, at the time of sexual contact and from blood products. It is endemic in certain populations such as Southeast Asians.[121]
I.	Herpes Simplex Virus-1	*	A viral infection that may be sexually transmitted.[94,121,147,148]
J.	Herpes Simplex Virus-2	*	A viral infection that is usually sexually transmitted.[94,121,147,148]
K.	Human immunodeficiency virus (HIV)	*	A sexually transmitted viral infection. May be transmitted at birth, through breast milk, blood products, semen, vaginal secretions and possibly other body fluids.[94,121,149-152]
L.	Lactobacillus	*	Anaerobic or microaerophilic organisms that occur widely in nature, including the mouth, vagina and intestinal tract.[121]
		*	Normal flora in the vagina of post-pubertal females.[121]
M.	Molluscum contagiosum	*	A common, benign, usually self-limited viral infection of the skin and conjunctiva by a poxvirus. Transmitted by autoinoculation, close contact. Primarily affects children but may also be seen in adolescents and adults in whom it may be sexually transmitted.[1,121]

N.	Moniliasis	*	Yeast (moniliasis) infection caused by Candida species.[1]
		*	*A common cause of "diaper dermatitis" in infants. An uncommon vaginal infection in prepubertal children.*[5,121]
O.	Syphilis	*	Infection caused by the spirochete *Treponema pallidum*.[1]
		*	*A sexually transmitted disease in most cases. May be transmitted to the fetus prior to or at the time of birth.*[121,153-156]
P.	Trichomonas Vaginalis	*	Single celled protozoan which is usually sexually transmitted.[121]
		*	*A cause of purulent vaginitis and may be associated with the presence of petechiae on the wall of the vagina and/or cervix.*[121]

GLOSSARY OF TERMS
and the
INTERPRETATION OF FINDINGS
for
CHILD SEXUAL ABUSE EVIDENTIARY
EXAMINATIONS

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PRACTICE

GUIDELINES

Please send all questions and comments to:

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Appendix N

Labeled Diagrams of Genital Structures

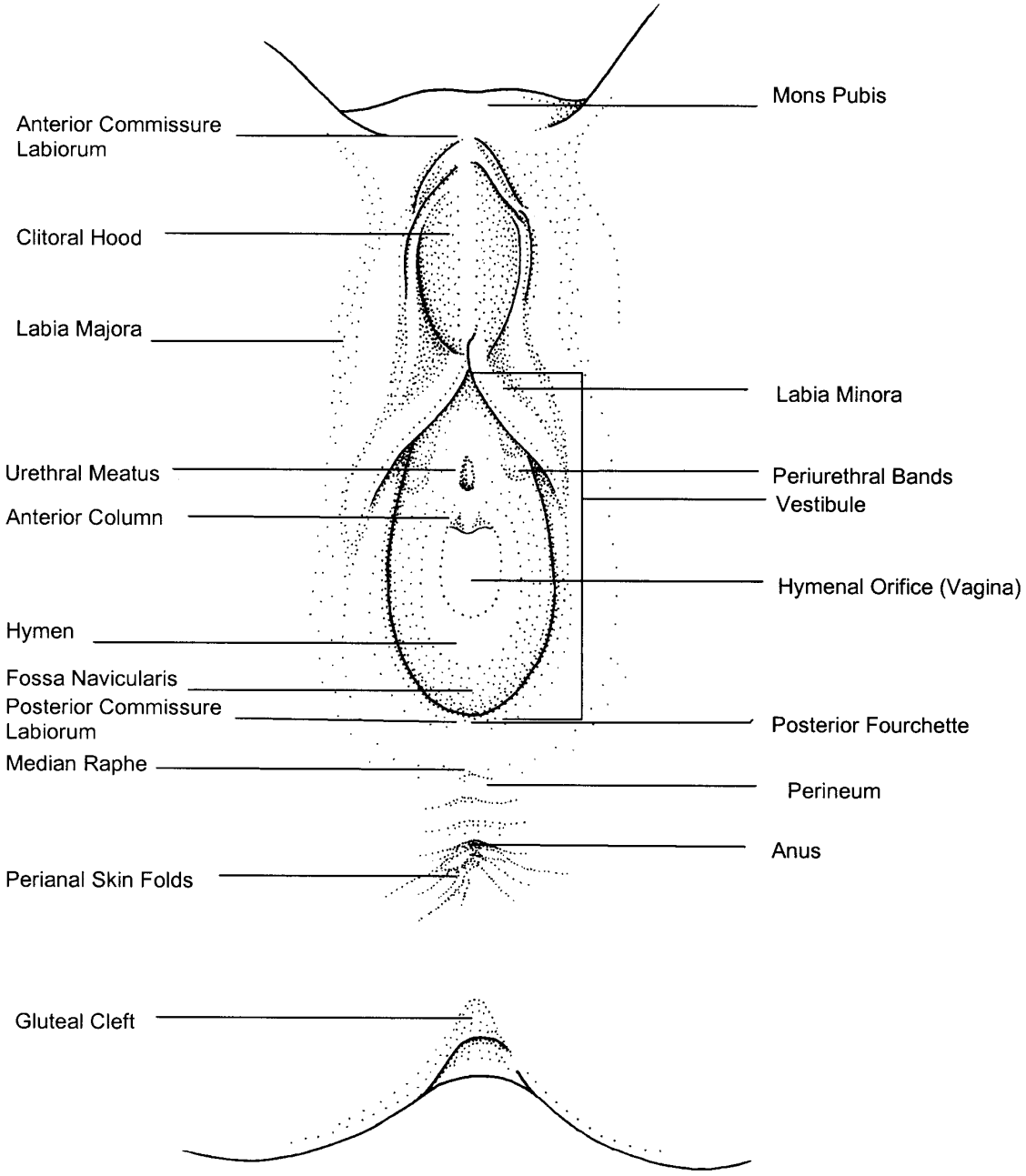
APPENDIX N
LABELED DIAGRAMS OF GENITAL STRUCTURES

FEMALE ANATOMY	
Clitoral hood:	sheath of skin covering clitoris at the anterior portion of the vulva; homologous with the penis in the male.
Labia majora:	("outer lips") rounded folds of skin forming the lateral boundaries of the vulva.
Urethral meatus:	the external opening of the urethra canal from the bladder.
Labia minora:	("inner lips") longitudinal thin folds of tissue enclosed within labia majora.
Hymen:	this membrane (external vaginal plate or urogenital septum) partially or rarely completely covers the vaginal orifice. This membrane is located at the junction of the vestibular floor and the vaginal canal.
Vagina:	the uterovaginal canal in the female. This internal structure extends from the uterine cervix to the inner aspect of the hymen.
Fossa navicularis:	concavity on the lower part of the vestibule situated posteriorly (inferiorly) to the vaginal orifice and extending to the posterior fourchette (posterior commissure).
Posterior fourchette:	the junction of two labia minora posteriorly (inferiorly). This area is referred to as a posterior commissure in the prepubertal child, as the labia minora are not completely developed to connect inferiorly until puberty, when it is referred to as the fourchette.
Vaginal vestibule:	an anatomic cavity containing the opening of the vagina, the urethra and the ducts of Bartholin's glands. Bordered by the clitoris anteriorly, the labia laterally and the posterior commissure (fourchette) posteriorly (inferiorly). The vestibule encompasses the fossa navicularis immediately posterior (inferior) to the vaginal introitus.

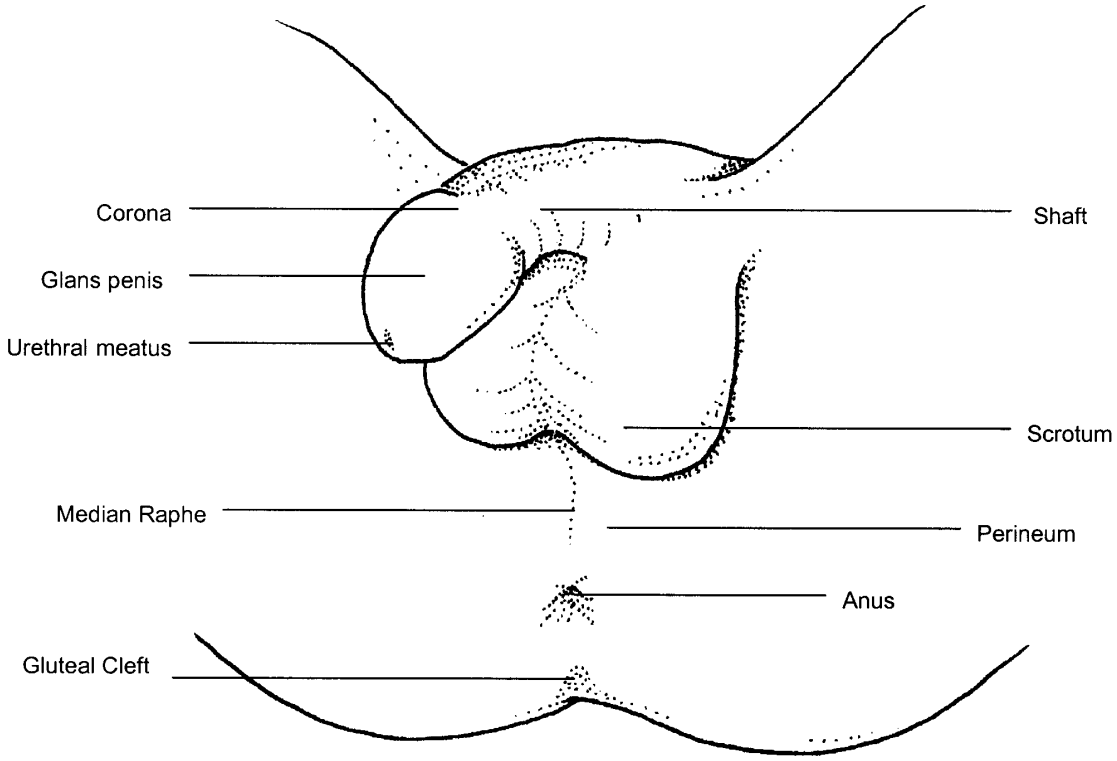
MALE ANATOMY	
Urethral meatus:	the opening of canal from the bladder.
Glans penis:	the cap-shaped expansion of the corpus spongiosum at the end of the penis; also called balanus. It is covered by a mucous membrane sheathed by the prepuce (foreskin) in uncircumcised males.
Corona:	posterior border of glans.
Shaft:	principal portion of penis.
Scrotum:	the pouch which contains the testicles and their accessory organs.

MALE/FEMALE ANUS/RECTUM	
Perineum:	the external surface or base of the perineal body, lying between the vulva and the anus in the female, and the scrotum and anus in the male.
Median raphe:	a ridge or furrow that marks the line of union of the two halves of the perineum.
Anus:	the anal orifice, which is the lower opening of the digestive tract, lying in the fold between the buttocks, through which feces are extruded.
Perianal folds:	wrinkles or folds of the anal verge skin radiating from the anus, which are created by contraction of the external anal sphincter.
Anal verge:	the tissue overlying the subcutaneous external anal sphincter at the most distal portion of the anal canal and extending to the margin of the anal skin.
Pectinate line/denate line:	the saw-toothed line of demarcation between the distal (lower) portion of the anal valves and the pectin, the smooth zone of stratified epithelium which extends to the anal verge. This line is apparent when the external and internal anal sphincters relax and the anus dilates.
Rectal ampulla:	the dilated portion of the rectum just proximal to the anal canal.
Gluteal Cleft:	a naturally occurring groove between the buttocks

APPENDIX N
LABELED DIAGRAM OF FEMALE GENITAL STRUCTURES



APPENDIX N
LABELED DIAGRAM OF MALE GENITAL STRUCTURES

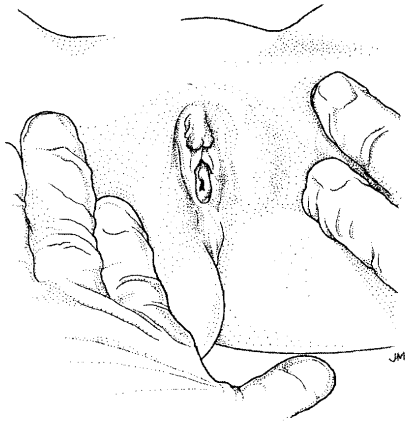


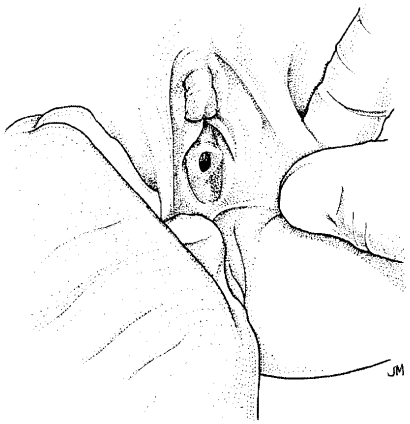
Appendix O

Illustrations of Examination Methods

APPENDIX O
ILLUSTRATIONS OF EXAMINATION METHODS

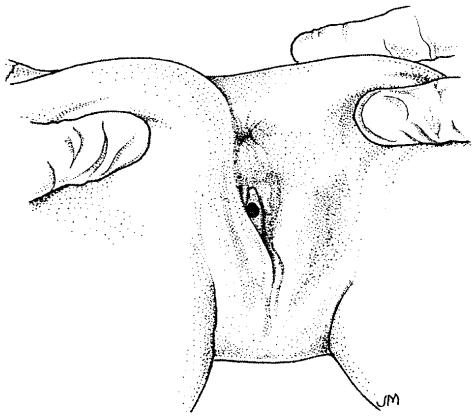
Supine Labial Separation





Supine Labial Traction

Prone Knee- Chest



Appendix P

Sample Discharge Instructions for Pregnancy and Sexually Transmitted Disease

APPENDIX P

Sample A

DISCHARGE INSTRUCTIONS FOR CHILDREN (younger than age 12) FOLLOWING A FORENSIC SEXUAL ASSAULT EXAMINATION

Patient name_____ Date_____ Examiner_____

Your child has received a forensic examination for evidence of sexual assault. It is important that you understand what tests were done and what follow-up care is recommended. It is in your child's best interest to follow the instructions below. Only the checked items apply to your child.

Your child had these tests:

☐ Blood serum tests for: ☐ *T. pallidum* (syphilis) ☐ Hepatitis B ☐ HIV

☐ Cultures for: ☐ *N. gonorrhoeae* (gonorrhea) ☐ *C. trachomatis* (chlamydia)

☐ Other: _____

Your child had these treatments:

☐ Ceftriaxone (125mg IM single dose)	• prevent/treat gonorrhea, a bacterial infection
☐ Doxycycline (8 years of age and older) 100mg orally 2x/day for 7 days	• prevent/treat chlamydia, a bacterial infection
☐ Erythromycin (younger than 8 years of age) 50mg/kg/day 4x/day for 10-14 days. Maximum dose is 2 grams/day.	• prevent/treat chlamydia, a bacterial infection
☐ Metronidazole 40 mg/kg single dose or 15mg/kg/day 3x daily for 7 days. Maximum dose is 2 grams/day.	• prevent/treat trichomonas, a protozoan infection
☐ Hepatitis B vaccine injection	• to prevent hepatitis B, a viral infection

☐ Other: _____

You have these prescriptions for your child:

☐ Other _____

☐ Other _____

☐ Other _____

Your child will need:

☐ A follow-up examination at _____

Please call ( )_____ to schedule an appointment.

☐ To repeat blood tests for syphilis and HIV infection in:

_____ (6 wks) _____ (12 wks), and _____ (24 wks)

☐ To complete two additional doses of Hepatitis B vaccine in:

_____ (1 mo.) and _____(4 mo.)

☐ Other:_____

☐ Other:_____

For information about:

- Your child's legal case: contact _____, the law enforcement agency that took the crime report at _____ (phone #). Your case number is _____.
- Victim Support Services: contact ( ) _____
- Therapy Services: contact ( ) _____
- If you need to contact you child's examiner call ( ) _____; after business hours call ( ) _____
- Medical emergencies: contact your child's own healthcare provider.

I have received and understand these instructions. _____
(signature of guardian)

APPENDIX P

Sample B

DISCHARGE INSTRUCTIONS FOR ADULTS AND ADOLESCENTS FOLLOWING A FORENSIC SEXUAL ASSAULT EXAMINATION

Patient name_____ Date_____ Examiner_____

You have received a forensic examination for evidence of sexual assault. It is important that you understand what tests were done and what follow-up care is recommended. It is in your best interest to follow the instructions below. Only the checked items apply to you.

You had these tests:

☐ Pregnancy test

☐ Blood serum tests for: ☐ *T. pallidum* (syphilis) ☐ Hepatitis B ☐ HIV

☐ Cultures for: ☐ *N. gonorrhoeae* (gonorrhea) ☐ *C. trachomatis* (chlamydia)

☐ Other: _____

You had these treatments:

☐ Cefixime (400mg orally single dose) (to prevent and treat gonorrhea, a bacterial infection)

☐ Azithromycin (1gram orally single dose) (to prevent and treat chlamydia, a bacterial infection)

☐ Ovral (2 oral pills) (to prevent pregnancy)

☐ Metronidazole (2 grams orally single dose) (to prevent and treat trichomoniasis, a protozoan infection)

☐ Hepatitis B vaccine injection (to prevent hepatitis B, a viral infection)

☐ Other: _____

You have these prescriptions:

☐ Ovral (2) pills to be taken orally at _____ (12 hours after the first dose that was given to you at the time of your exam) to prevent pregnancy. It is not unusual to feel nausea and to vomit; food or milk is recommended.

☐ Doxycycline 100mg pills to be taken orally twice a day for seven days to prevent Chlamydia.

☐ Other _____

You will need:

☐ A follow-up examination at _____.

Please call ( )_____ to schedule an appointment.

☐ To repeat blood tests for syphilis and HIV infection in:

_____ (6 wks) _____ (12 wks), and _____ (24 wks)

☐ To complete two additional doses of Hepatitis B vaccine in: _____(1 mo.) and _____(4 mo.)

☐ Other:_____

☐ Other:_____

For information about:

- Your legal case: contact _____, the law enforcement agency that took the crime report at _____ (phone #). Your case number is _____.
- Victim Support Services: contact ( ) _____
- Therapy Services: contact ( ) _____
- If you need to contact your examiner call ( ) _____; after business hours call ( ) _____
- Medical emergencies: contact your own healthcare provider.

I have received and understand these instructions. _____

(signature of patient)

Appendix P

Sample C

DISCHARGE INSTRUCTIONS FOR ADULTS AND ADOLESCENTS
FOLLOWING A SEXUAL ASSAULT EXAMINATION

1. Your evidentiary exam was done on _____ by _____
   (date) (examiner's name)

   All specimens have been delivered to the _____ Crime Lab except the cultures for gonorrhea and Chlamydia and a blood test for syphilis. These have been retained for analysis at _____

2. To find out the results of your cultures and blood tests, call ( ) _____ in four days. Please call between 10 AM and 6 PM seven days a week and have your patient identification number available when you call.

   Your identification number is _____.

3. Rape crisis counseling is available through _____
   The 24 hour crisis line is ( ) _____
   To make an appointment for counseling, call ( ) _____
   Your advocate was _____

4. If you were given pregnancy prevention medication (emergency contraception), an information sheet on the method will be attached.
   Medication Given ☐ Yes ☐ No
   Name of medication _____ Number of Pills _____

5. You should have the following tests done in two (2) weeks.
   - ☐ Cervical culture for gonorrhea and Chlamydia
   - ☐ Throat culture for gonorrhea
   - ☐ Rectal culture for gonorrhea
   - ☐ Urethral culture for gonorrhea
   - ☐ Urine pregnancy test
   - ☐ Other _____

   Make an appointment to have this done by your private doctor or by one of the clinics listed.

6. In six (6) weeks, you should have the following tests done:
   - ☐ Blood test for syphilis

7. You have been treated for possible exposure to a sexually transmitted disease with the following:
   - ☐ Cefixime (400mg orally single dose)
   - ☐ Azithromycin (1 gram orally single dose)
   - ☐ Doxycycline (100mg orally twice daily for seven days)
   - ☐ Ofloxin (400mg orally single dose)
   - ☐ Erythromycin (500mg orally four times per day for seven days)
   - ☐ Metronidazole (2 grams orally single dose)
   - ☐ Other: _____

8. You have been offered Hepatitis B vaccine for possible exposure to the hepatitis B virus.

   Hepatitis B vaccine given? ☐ Yes ☐ No

   You will need to complete the vaccination series by receiving an additional hepatitis B vaccine:

   ☐ One (1) month ☐ Six (6) month

9. Special forensic follow-up is need to re-evaluate your injuries:

   ☐ Your appointment is scheduled for _____ at _____
   (date) (time)

   ☐ Call _____ to arrange a follow-up exam in _____ days.

10. AIDS (HIV) TESTING:

    You have been given information about the risk of AIDS from a sexual assault. Even though it is unlikely that you have been exposed to or contracted the AIDS (HIV) virus, we recommend that you be tested.

    Two types of testing exists:

    ANONYMOUS TESTING (at some clinics): No record is kept of the test results after they are given to you. No one (employers, insurance companies) will ever know that you have been tested; however, there will be no documentation or proof of the test results.

    CONFIDENTIAL TESTING: The results of the test are kept on file but are confidential and subject to the same rules that apply to patient medical records. If the results of the test become important for future reference, they can be retrieved.

    The AIDS (HIV) virus is not detectable in the blood for at least two months after exposure. However, to prove that you were not infected with the AIDS virus before you were sexually assaulted, you will need a <u>baseline</u> confidential test within one week of your evidentiary exam. You will need to decide if you wish to obtain a baseline test. Otherwise, we recommend repeat testing at three (3) months, six (6) months, and one (1) year.

11. If you have not been contacted by law enforcement about your assault after one week and you wish to inquire, call:

    ☐ _____ Police Department at ( ) _____

    ☐ _____ Sheriff's Department at ( ) _____

    ☐ Other: _____

12. If you are a Kaiser patient, we will arrange a follow-up examination.

APSAC AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

Practice Guidelines

Glossary of Terms and the Interpretation of Findings For Child Sexual Abuse Evidentiary Examinations

Introduction

This document was developed to further clarify the terminology currently being used in the field of childhood sexual abuse and to assist professionals attempting to determine the significance of ano-genital findings.

This glossary was prepared to assist other professionals who conduct or endeavor to interpret child sexual abuse medical evaluations or who may use *APSAC's Practice Guidelines: Descriptive Terminology in Child Sexual Abuse Medical Evaluations*. Whenever possible, the definitions used in this document were taken from those Guidelines. Additional terms, such as "intact hymen," were included to inform professionals that the use of such terms is to be discouraged because of their lack of specificity.

The interpretations used in this document have been derived from studies previously published in peer reviewed journals. A conscious attempt was made to avoid unsubstantiated interpretations of ano-genital findings. As with the *Descriptive Terminology Guidelines*, it is anticipated that revisions will occur in this document as our scientific knowledge and experience growth.

TABLE OF CONTENTS

DEFINITION OF TERMS

I. General Terms/Definitions

A.	Abrasion	An area of body surface denuded of skin or mucous membrane by some unusual or abnormal mechanical process. An injury.[1]
B.	Colposcope	An instrument with a light source and magnifying lens for direct observation and study of the tissues. May have a camera and/or other recording devices attached.[2,3,4]
C.	"Clue cells"	Vaginal epithelial cells with clusters of bacteria adhering to the surface. Associated with Bacterial Vaginosis, an over-growth of several organisms including Gardnerella vaginalis.[5,6,7,8]
		A common finding in sexually active females.[5,7]
D.	Cunnilingus	Oral stimulation of the female genitalia.[1]
E.	Descriptive Terms	
1.	Anterior	Situated in front of or in the forward part of an organ, toward the head of the body; a term used in reference to the ventral or belly surface of the body.[1]
2.	Posterior	Situated in back of, or in the back part of; a term used in reference to the back or dorsal surface of the body.[1]
3.	Inferior	Situated below, or directly downward; a term used in reference to the lower surface of an organ or other structure.[1]
4.	Superior	Situated above, or directly upward; a term used in reference to a structure occupying a position near the vertex.[1]
5.	Cephalad	Toward the head; opposite caudad.[1]
6.	Caudad	*Directed toward the tail; opposite cephalad [1]
7.	Dorsal	1) Pertaining to the back. 2) denoting a position more to the back.[1]
8.	Ventral	1) Pertaining to the belly. 2) denoting a position more toward the belly surface than some other object of reference; same as anterior in human anatomy.[1]
9.	Distal	A term denoting the remoteness from the point of origin or attachment of an organ of part.[1]
10.	Proximal	Nearest; closer to any point of reference opposed to distal.[1]
11.	Peri	A prefix meaning "around."[1]

12. Clock position reference

A method by which the location of a structure may be designated by using the numerals on the face of a clock. The 12 o'clock position is always superior (up). The 6 o'clock position is always inferior (down). The position of a patient must be indicated when using this designation.[9]

F. Ecchymosis

A hemorrhagic area on the skin due to extravasation of blood into the skin or a mucous membrane.[1]

A bruise.

G. Elasticity

The state or quality of being distensible; Flexibility; adaptability.[1] Example: A hymen that changes its configuration with the different examination methods and/or positions. *An inexact term that should be avoided.*

H. Erythema

A redness of the skin or mucous membranes produced by congestion (dilation) of the capillaries.[1] (Redness of tissues).

I. Estrogenized

Effect of influence by the female sex hormone estrogen resulting in changes to the genitalia.[1]

The hymen takes on a thickened, redundant and pale appearance as the result of estrogenization. These changes are observed in infants, with the onset of puberty, and as the result of exogenous estrogen.[1]

J. Examination methods

1. Knee-chest Position Method (prone)

With the patient in a knee-chest position, the examiner places thumbs beneath the leading edge of the gluteus maximus and lifts while gently separating labia.[10-20]

2. Labial Separation

The labia majora are gently separated in a lateral and downward direction, exposing the vestibule.[10-17,20]

3. Labial Traction

The labia majora are grasped between the thumbs and index fingers and gently pulled toward the examiner. Usually performed in the supine position.[16,17,19,20,21,22]

K. Examination Positions

1. Frog Leg Position

Examination position in which the patient lies in supine (lying on back, face upward) position with knees flexed and hips abducted. The bottoms of feet touch. [10-18]

2. Knee-chest Position (prone)

Examination position during which the patient rests on knees with the upper chest on the examination table in a

			lordotic ("sway-backed") posture. Elbows are flexed with hands placed on either side of the head.[1,10-18,20]
	3.	Knee-chest Position (supine)	Examination position during which the patient lies on his/her back with the hips flexed upon the abdomen.[13,16,19,20]
	4.	Lateral Decubitus (Recumbent)	Examination position in which the patients lies on side with the contra lateral thigh and knee drawn up; also called lateral recumbent position.
	5.	Lithotomy position	Examination position in which the patient lies on his/her back with his/her hips and knees flexed and the thighs abducted and externally rotated.[1]
	6.	Prone Position	Examination position in which the patient lies face downward (on his/her abdomen).[1]
	7.	Supine Position	Examination position in which the patient lies (on his/her back) with their face upward.[1]
L.	Fellatio		Oral stimulation or manipulation of the penis.[1]
M.	Fordyce's Granule		Ectopic sebaceous glands found on the labia which present as yellowish white milia or papule.[1]
N.	Friability		A term used to describe tissues that bleed easily, such as a labial adhesion when gently separated. Friability of the posterior fourchette - A superficial breakdown of the skin in the posterior fourchette (commissure) when gentle traction is applied, causing slight bleeding.[9] A non-specific finding.
O.	Hemorrhoid		A varicose dilatation of a vein of the superior or inferior hemorrhoidal plexus, resulting from a persistent increase in venous pressure.[1]
P.	Genitalia (External)		The external sexual organs, In males, includes the penis and scrotum. In females, includes the contents of the vulva.[1]
Q.	Hyperemia		An excess of blood in a part; engorgement of the blood vessels.[1]
R.	Hyperpigmentation		Increase in melanin pigment within tissues.[1] A common finding in darker skinned children. May be congenital in nature or caused by a past inflammatory response.[23]

S.	Inflammation	A localized protective response of tissues, elicited by injury or destruction of tissues, which is usually characterized in the acute form by the classical signs of pain, heat, redness, swelling and loss of function.[4]
T.	"Intact hymen"	A term used in the past which implied a non-injured hymenal membrane.[11,24,25] The use of this term is to be discouraged.
U.	Intracrural intercourse (intralabial, dry or vulvar intercourse)	The act of rubbing the penis between the labia of the female without entering the vagina.[22,24-28]
V.	Laceration	A transection (cut) through the skin, mucous membranes or deeper structures of the body.[1] A tear through the full thickness of the skin or other tissue.[9]
W.	Leukocytes	White blood cells or corpuscles (pus) that are part of the inflammatory response to an infection.[1]
X.	Leukorrhea	A whitish, viscid (glutinous) discharge from the vagina and uterine cavity through the cervical os.[1] normal finding in adolescent and adult females. The term **physiologic discharge** is sometimes used instead.[29,30]
Y.	Lichenification	Thickening of the skin markings, giving the skin a leathery appearance. Usually secondary to prolonged irritation secondary to rubbing, scratching or inflammation.[1,26]
Z.	Lichen Sclerosis et Atrophicus	A rare, chronic, atrophic skin disease characterized by homogeneous hypopigmented areas.[1,31-36] It is the most common cause of kraurosis vulvae in females and balanitis xerotica obliterans in males.[1] May initially be confused with injuries resulting from a sexual assault.[35,36]
AA.	"Marital introitus"	An enlarged hymenal orifice. **The use of this term is to be discouraged.**

BB.	Neovascularization	New blood vessel formation in abnormal tissue or in an abnormal location.Revascularization.[1] A seldom used term due to the inability to verify.[37] The use of this term is to be discouraged.
CC.	Pelvic inflammatory disease	Infection of the uterus, fallopian tubes and/or ovaries (Salpingo-oophoritis). Commonly called "PID".[1] Usually caused by an ascending gonorrhea, chlamydia, aerobic or anaerobic bacterial infection.[27,38]
DD.	Perineal Body	The central tendon of the perineum. Located between the vestibule and the anus in the female and between the scrotum and anus in the male.[9]
EE.	Petechiae	Small, pinhead sized hemorrhages caused by leaking capillaries. May be singular or multiple.[1] Frequently caused by increased pressure within the blood vessel, as with straining during vomiting or with strangulation. May also be caused by a bleeding disorder, infection or localized trauma.[1,28]
FF.	Scar	Fibrous tissue which replaces normal tissue after the healing of a wound.[9] May be difficult to prove on clinical grounds, such as during visual inspection or palpation alone.
GG.	Sodomy	In medical usage, this term is restricted to anal intercourse.[1]
HH.	Straddle Injury	An injury to the perineum when the individual falls on an object while the legs are spread apart.[1,41]
II.	Synechiae	Any adhesion which binds two anatomic structures through the formation of a band of fibrous or scar tissue.[1,9]
JJ.	Tanner Scale of Secondary Sexual Development	A sexual maturity rating scale that defines the stage of puberty by physical evidence of breast development and pubic hair in the female. The testicular/scrotal and penile size plus the location and type of pubic hair are used in the male. Stages range from Stage I (prepubertal child) to Stage V (fully mature adult).[40]

KK.	Transection	A cutting across. Division by cutting or tearing transversely.[1]
	(Complete Hymenal)	A tear or laceration through the entire width of the hymenal membrane extending to its attachments to the vaginal wall.[9]
	(Partial Hymenal)	A tear or laceration through a portion of the hymenal membrane not extending to its attachment to the vaginal wall.[9]
		The strict definition of the term "transection" implies a complete tear through the entire width of a membrane. **Therefore, the use of the term "<u>partial</u> <u>transection</u>" is to be discouraged**. The term partial tear is suggested.
LL.	Vascularity (Increased or Prominent)	Dilation of existing superficial blood vessels.[9]
MM.	Vulvar Coitus (Intralabial or Intracrural Intercourse)	Rubbing of the penis between the labia of the female without entering the vagina.[26,41,42]

II. Female

A.	Mons Pubis	The rounded fleshy prominence, created by the underlying fat pad, which lies over the symphysis pubis (pubic bone) in the female.[9]
B.	Perineum	The external surface or base of the perineal body, lying between the vulva and the anus in the female. Underlying the external surface of the perineum is the floor and its associated structures occupying the pelvic outlet which is bounded anteriorly by pubic symphysis (pubic bone), laterally by the ischial tuberosities (pelvic bones) and posteriorly by the coccyx (tail bone).[1,9]
C.	Vulva	The external genitalia or pudendum of the female. Includes the mons pubis, clitoris, labia majora, labia minora, vaginal vestibule, urethral orifice, vaginal orifice, hymen, and posterior fourchette (or commissure) [25,45]
1.	Vulvitis	Inflammation of the labia and vestibule.[1]
		May be caused by a variety of irritants, such as, but not limited to improper wiping techniques, poor hygiene, bubble bath, shampoo or infectious agents.[44-47]
2.	Vulvar coitus	Rubbing of the penis between the labia of the female without entering the vagina.[26,41,42]

D. Clitoris/Clitoral Hood

1. Clitoris

A small cylindric, erectile body, situated at the anterior (superior) portion of the of the vulva, covered by a sheath of skin called the clitoral hood; homologous with the penis in the male.[1,9,43]

2. Clitoral Hood

The skin covering the clitoris. Homologous with the prepuce (foreskin) in the male.1

May become erythematous and edematous from contact with a variety of irritants or from trauma.[44-47]

E. Labia

1. Labia Majora (Outer Lips)

Rounded folds of skin forming the lateral boundaries of the vulva.[9,43]

2. Labia Minora (Inner Lips)

Longitudinal, thin folds of tissue within the labia majora. In the prepubertal child, these folds extend from the clitoral hood to approximately the midpoint on the lateral wall of the vestibule. In the adult, they enclose the vestibule and contain the opening to the vagina.[9,43]

Commonly injured in accidental straddle injuries.[48-50]

3. Labial Adhesion (Agglutination)

The result of adherence (fusion) of the adjacent, outer-most, mucosal surfaces of the posterior portion vestibular walls. This may occur at any point along the length of the vestibule although it most commonly occurs posteriorly (inferiorly).[9,51,52]

A common finding in infants and young children. Unusual to appear for the first time after 6 to 7 years of age. May be related to chronic irritation.[53-55]

F. Vestibule (Vaginal)

An anatomical cavity containing the openings of the vagina, the urethra and the ducts of Bartholin's glands. Bordered by the clitoris anteriorly, the labia on the sides and the posterior commissure (fourchette) posteriorly (inferiorly). The vestibule encompasses the fossa navicularis immediately posterior (inferior) to the vaginal introitus.[1,9,43]

1. Anterior Commissure

The union of the two labia minora anteriorly (toward the clitoris). [9,43]

May be torn as a result of a straddle injury or by forceful separation of the labia minora.[50]

2.	Erythema	A redness of the skin or mucous membrane produced by congestion or dilatation of the capillaries.[1] Redness of tissues.[9] A non-specific finding caused by local irritants, inflammation, infections or trauma.[44-47]
3.	Urethra	The membranous canal which conveys urine from the bladder to the exterior of the body.[1]
	a) Urethral Dilatation	An enlargement of the urethral meatal aperture. A normal variant when labial traction examination technique is employed.[16,56]
	b) Urethral Meatus	External opening of the canal (urethra) from the bladder.[1]
	c) Urethral Prolapse	Evagination of the lining of the urethra.[1] May present as bleeding from the female genitalia. Most commonly occurs in African/American children.[57,58] Relationship to sexual abuse has not yet been determined.
	d) Urethritis	Inflammation of the urethra.[1] May be caused by a variety of irritants (such as bubble bath) and infections.[44-47]
4.	Periurethral	Pertaining to tissue surrounding the urethral meatus.[1]
	a) Periurethral Bands (Pubo-urethral Bands)	Small bands, lateral to the urethra, that connect the periurethral tissues to the wall of the vestibule. These bands are usually symmetrical and frequently create a semi-lunar shaped space between the bands on either side of the urethral meatus. Also called urethral support ligaments.[4,56,59-63] Found in the majority of females and accentuated when the labial traction examination technique is used.[16,56,59,60]
5.	Hymenal Orifice	The opening to the vagina through the hymenal membrane.[43]

6.	Perihymenal	Pertaining to tissues surrounding the hymen.[1]
	a) Perihymenal Bands (Pubo-vaginal)	Small bands of tissue, lateral to the hymen, that form a connection between the perihymenal structures and the wall of the vestibule.[4,56,59-63] A less frequently observed finding than periurethral bands in prepubertal girls. Accentuated when the labial traction examination method is used.[16,56,59-63] Usually a congenital variation. Rarely caused by trauma.[53,54,59]
7.	Vaginal Introitus	(Sphincter vaginae) The pubovaginalis muscle that forms the entrance to the vagina. The muscular bulbospongiosus in the female.[1]
8.	Follicles	Small (1-2 mm) clear or yellow colored papules on the hymen and/or surrounding tissues that appear to contain lymph-like material.[4,56,62] Etiology is uncertain.
9.	Fossa Navicularis	Concavity of the lower part of the vestibule situated posterior (inferior) to the vaginal orifice and extending to the posterior fourchette (posterior commissure).[9,43] May be injured as a result of a straddle injury or a sexual assault.[39,48-52]
	a) Asymmetry of Fossa Navicularis (Puborectal bands)	The posterior commissure attachment of labia minora joins the fossa at different levels creating an asymmetrical appearance and occasionally a band-like configuration.[56] A relatively common finding of no significance.[56]
	b) Linea Vestibularis (Midline sparing)	A vertical, pale/avascular line across the posterior fourchette and/or fossa navicularis, which may be accentuated by putting lateral traction on the labia majora.[9,13,56,59,65,66] A common finding that is found in girls of all ages including newborns and adolescents.[59,65,66]

11. Posterior Commissure

The union of the two labia posteriorly (toward the anus).[9]

The junction of two labia minora posteriorly (inferiorly). This area is referred to as a posterior commissure in the prepubertal child. In children, the labia minora are not completely developed and do not connect inferiorly until puberty. In the postpubertal female, it is referred to as the posterior fourchette.[9]

May be injured as the result of a straddle injury or during a sexual assault.[39,50,67]

G. Hymen

A membrane which partially or rarely, completely covers the external vaginal orifice. Located at the junction of the vestibular floor and the vaginal canal.[1,9,68-72]

The external surface is lined with highly differentiated squamous epithelium with loose cornification. The internal surface is lined with vaginal epithelium. Origin is the external vaginal plate of the urogenital sinus.[68] Wide anatomic variation in types: annular, crescentic, fimbriated (denticular), septate, cribriform, imperforate.[13,14,15,56,59,62,63,68,69]

Wide variation in character of membrane: redundant/thick vs. smooth/thin (velamentous) depending upon age and stage of secondary sexual development.[13,14,15,56,59,62,63,68,69]

All females with a normal Mullerian system and normal external genitalia have this structure.[59]

1. Angularity of Hymen

Relatively sharp angles in the contour of the hymenal inner edge.[64,75]

When finding is located on the posterior hymenal rim and persists during multiple examination techniques it may be evidence of hymenal trauma.[64,75,76,77]

3. Annular (Circumferential)

The hymenal membrane extends completely around the circumference of the vaginal orifice.[9]

The most common configuration in the newborn and young infant.[59,69,72,78]

3. Anterior (Superior) Hymenal Wings (Flaps)

Bilateral projections of tissue on the anterior (superior) edge of the hymen.[79]

A common finding in infants and children less than five years of age as well as during the onset of puberty. A normal physiologic tissue response to estrogens.[79]

4.	Attenuated Hymen	The term has been used to describe areas where the hymen is narrow.[76,77,90] The term should be restricted to indicate a documented change in the width of the posterior portion of the hymen following an injury.[9]
5.	Caruncula Myrtiformis (Hymenales)	Small elevations of rounded mounds of hymen encircling the vaginal orifice.[1] *Found in sexually active and postpartum females.*[1,2,80]
6.	Cleft/notch	An angular or "V"-shaped indentation on the edge of the hymenal membrane. May extend to the muscular attachment of the hymen.[2,4,75] A relatively sharp, "V"-shaped notch or cleft, that persists during multiple examination techniques may be evidence of hymenal trauma.[64,75]
7.	Cleft (Anterior)	A shallow indentation of the hymenal membrane that does not extend to the attachment of an annular hymen.[59,60] Girls with a crescent shaped hymen appear to have an absence of the membrane between the 11 and 1 o'clock positions. In this situation the term "anterior sparing" is preferable. Newborns frequently have a cleft or notch in the midline of the hymen superiorly. This may be the antecedent of the crescent shaped hymen.[56,69,81]
8.	Cleft (Lateral)	An indentation along the lateral (2 to 4 and 8 to 10 o'clock positions with the child supine) margins of the hymen.[1,59,63] Must be interpreted with caution, particularly if there are bilateral, smooth edged, symmetrical clefts, which may represent naturally occurring variations. May be found in sexually active females.[56,59,63,76,80]
9.	Clefts (Posterior)	An indentation in the posterior (4 to 8 o'clock positions with the child supine) edge of the hymen.[2,17,25,50,64,82] Clefts in the posterior rim, that persist during multiple examination techniques are usually evidence of hymenal trauma.[59,61,64,65,75,76]
10.	Concavity (Depression)	A curved or hollowed "U"-shaped depression on the edge of the hymenal membrane.[1]
11.	Cribriform	A hymen with multiple openings.[9,43] A congenital variant.[9,43]

12.	Crescentic	Hymen with anterior attachments at approximately the 11 o'clock and the 1 o'clock positions with no hymenal tissue visible between the two attachments.[9,17,56,59,69] The most common hymenal configuration in the school aged, prepubertal child.[56,60]
13.	Cyst (Hymenal)	A fluid filled sac of tissue confined within the hymenal tissue.[1,9,63,83] Considered to be a normal variant.[63,83]
14.	Erythema of the Hymen	A redness of the hymenal membrane produced by congestion [engorgement] of the capillaries.[1] A non-specific finding. May result from a variety of irritants as well as direct trauma.[44,45,46,47,63]
15.	External Hymenal Ridge	A midline, longitudinal ridge of tissue on the external surface of the hymen. May be either anterior or posterior. Usually extends to edge of the membrane.[9,59,63] A congenital variant most commonly found during the newborn period or infancy.[59,63]
16.	Fimbriated/Denticular	Hymen with multiple projections or indentations along the edge, creating a ruffled appearance.[1] A congenital variant.[69]
17.	Hymenal Orifice	The opening in the hymenal membrane which constitutes the entrance or outlet of the vagina.[1]
18.	Hymenal Orifice's Diameter	The distance from one edge of the hymen to the opposite edge of the hymenal orifice. The most common measurement used is the horizontal (lateral) diameter.[14,16,84,85] Hymenal orifice size varies with the age of the child, the examination technique and other factors such as the state of relaxation.[16,56,86] **Size of the hymenal orifice should be used with caution in determining if prior sexual abuse has occurred**.
19.	Imperforate	A hymenal membrane with no opening.[9] An uncommon congenital variant.[56]

20. Inflammation	(Hymenal) A localized protective response elicited by injury or destruction of tissues.[1] A non-specific finding that can result from a variety of causes including trauma.[44-47]
21. Irregular Hymenal Edge	A disruption in the smooth contour of the hymen.[64,75,87,88] A general descriptive term requiring further definition.
22. Key-Hole Configuration	A "Key-hole" appearance of the hymenal orifice is created when the posterior-lateral portions of the hymenal membrane project into the orifice creating a concavity inferiorly.[4] A descriptive term that may be misinterpreted. **Recommend avoidance**.
23. Laceration of the Hymen (Acute Transection)	An injury or tear of the hymenal membrane that is usually associated with a blunt force penetration.[64,75,82]
24. Mound (Bump)	A solid, localized, rounded and thickened area of tissue on the edge of the hymen.[9] May be created by the hymenal attachment of a longitudinal intravaginal ridge (LIR).[56,59,60,61]
25. Narrow Hymenal Membrane (Rim) (Attenuated)	The term used to describe the width of the hymenal membrane as viewed in the coronal plane, i.e. from the edge of the hymen to the muscular portion of the vaginal introitus (opening).[9] An abnormally narrow hymenal membrane may be evidence of prior trauma.[4,15,64,76,82,90,91,92]
26. Notch/cleft (Hymenal)	An angular or "V" shaped indentation on the edge of the hymenal membrane.[1] May extend to the muscular attachment of the hymen. A relatively sharp, "V"-shaped notch or cleft, that persists during multiple examination techniques may be evidence of hymenal trauma.[59,61,64,65,75,76]
27. Perihymenal	Pertaining to tissues surrounding the hymen.[1]

28.	Perihymenal Bands (Pubo-vaginal)	Bands of tissue, lateral to the hymen, that form a connection between the perihymenal structures and the wall of the vestibule.[9] A less frequently observed finding than periurethral bands. Accentuated when the labial traction examination method is used.[16,56,59-63] Usually a congenital variant. Rarely caused by trauma.[53,56,59]
29.	Redundant Hymen	Abundant hymenal tissue which tends to fold back upon itself or protrude [9] A common finding in females whose hymenal membranes are under the influence of estrogen (Both infants and adolescents).[56,59,62,76]
30.	Rolled Edges	The edge (border) of the hymen which tends to roll inward or outward upon itself. May unfold through the use of the knee-chest position, application of water, through manipulation with a moistened Q-tip or other techniques.[37,16,17,62,76,77,90] A normal variant most commonly noted in prepubertal children.[16,56]
31.	Rounded Edges	Hymenal edges that appear thick and rounded and do not thin out with the different examination techniques, the application of water or other maneuvers used to unroll an elastic, redundant hymen.[37,56] May be the result of hormonal influence, poor relaxation, an inflammatory reaction, the attachment of an underlying intravaginal longitudinal ridge or past injury.[17,37,56,62,76,77,90]
32.	Scalloped Edges	A series of rounded projections along the edge of the hymen.[62] A common finding in early adolescence.[79]
32.	Septal Remnant (Hymen Subseptus)	A small appendage (tag) attached to the edge of the hymen. Commonly located in the midline on the posterior rim. Frequently associated with a concomitant thickened ridge on the hymen which extends from the appendage (septal remnant) to the muscular attachment of the vaginal introitus. May be associated with similar appendage on opposite side of hymenal orifice. (Similar to hymenal tags.)[56]

		Considered to be a normal variant.[56,59,81] A diagnosis by implication unless an intact septum was previously seen.
	33. Septated Hymen	A hymen with band(s) of tissue, which bisects the orifice creating two or more openings.[9,62,63,69,76,78,81,92,93,94,95,96] A congenital variant.[59,78,81,95,96]
	35. Tag (Hymenal)	An elongated projection of tissue arising from any location on the hymenal rim. Commonly found in the midline and may be an extension of a posterior vaginal ridge.[9] Usually a congenital variant. Rarely caused by trauma.[59,63,93,94]
	36. Thickened edge	A term used to describe the relative amount of tissue between the internal and external surfaces of the hymenal membrane.[9] May be the result of hormonal influence, poor relaxation, the attachment of an underlying intravaginal longitudinal ridge or past injury.[37,56,59,60.61,63]
	37. Transection of hymen (complete)	A tear or laceration through the entire width of the hymenal membrane, extending to (or through) its attachment to the vaginal wall.[9]
	38. Transection of hymen (partial)	A tear or laceration through a portion of the hymenal membrane, <u>not</u> extending to its attachment to the vaginal wall.[9] The strict definition of the term "transection" implies a complete tear through the entire width of a membrane. Therefore, the use of the term "**<u>partial</u> <u>transection</u>**" is to be discouraged. The term <u>partial tear</u> is suggested.
H.	Posterior Fourchette	The junction of two labia minora posteriorly (inferiorly). This area is referred to as a posterior commissure in the prepubertal child. In children, the labia minora are not completely developed and do not connect inferiorly until puberty. In the postpubertal female, it is referred to as the posterior fourchette.[9]
	1. Friability	A superficial breakdown of the skin of the posterior commissure when gentle traction is applied, causing a slight bleeding.[9] Considered to be a non-specific finding.

2.	Linea Vestibularis (Midline sparing)	A vertical, pale/avascular appearing line across the posterior fourchette and/or fossa navicularis, which may be accentuated by putting lateral traction on the labia majora.[9,56,65,66] A common finding that is found in girls of all ages, including newborns and adolescents.[56,59,65,66]
3.	Median (Perineal) Raphe	A ridge or furrow that marks the line of union of the two halves of the perineum.[1,9,97]
4.	Midline Commissure	The site of union of corresponding parts. i.e. anterior or posterior commissure of the labia minora.[1]
5.	Perineal Groove	Developmental anomaly, also called "Failure of Fusion". A midline defect in the median raphe in which the skin and/or mucosal surfaces fail to fuse. May involve any part of the median raphe, from the fossa to the anus.[9,39]
6.	Posterior Commissure	The union of the labia minora posteriorly (inferiorly). Forms the posterior fourchette.[9]
I.	Vagina	The uterovaginal (genital) canal in the female. This internal structure extends from the uterine cervix to the inner aspect of the hymen.[9]
1.	Intravaginal Columns (columnae rugarum vaginae)	Raised (sagittally oriented) columns most prominent on the anterior wall with less prominence on the posterior wall.[9]
2.	Intravaginal Longitudinal Ridges (ILR)	Narrow, mucosa-covered ridges of tissue on the vaginal wall that may be attached to the inner surface of the hymen. They may be located in all four quadrants and are usually multiple in number.[56,59,63] A normal finding.[56,59,63]
3.	Posterior	Fornix A cavity within the vagina and located posteriorly (inferior) to the cervix.[1]
4.	Rugae (Vaginal)	Folds of epithelium (rugae) running circumferentially from the vaginal columns.[9] A normal finding.[56]

5.	Vaginal Introitus	The pubovaginalis muscle which forms the entrance to the vagina. Frequently used synonymously with hymenal orifice.
6.	Vaginitis	Inflammation of the vagina; it may be marked by a purulent discharge and discomfort.[1] May be caused by a variety of conditions, including bacterial vaginosis, sexually transmitted diseases, foreign bodies, to name a few. [44,45,46,47,99,100,101,102,103]

III. Male

A.	Balanitis	Inflammation of the glans penis; it is usually associated with phimosis.[1] Usually a non-specific finding.
B.	Corona of glans penis	The rounded proximal border of the glans penis, separated from the corpora cavernosa penis by the neck of the glans.[1]
C.	Frenulum	A small fold of mucus membrane that attaches the prepuce to the ventral surface of the penis.[1]
D.	Glans penis	The cap-shaped expansion of the corpus spongiosum at the end (head) of the penis; also called balanus. It is covered by a mucus membrane and sheathed by the prepuce (Foreskin) in the uncircumcised male.[1,9]
E.	Median (Perineal) raphe	A ridge or furrow that marks the line of union of the two halves of the perineum.[1,9]
F.	Paraphimosis	Retraction of the phimotic foreskin, causing a painful swelling of the glans that, if severe, may cause dry gangrene unless corrected.[1]
G.	Penis	Male sex organ composed of erectile tissue through which the urethra passes. Homologous with the clitoris in the female.[1,9] The penis is rarely injured as the result of sexually motivated abuse.104-108
H.	Phimosis	Constriction of the preputial orifice which limits the retraction of the prepuce (foreskin) back over the glans.[1]
I.	Posthitis	Inflammation of the prepuce (foreskin).[1]
J.	Prepuce (Foreskin)	A covering fold of skin over the glans of the penis. (preputium penis).[1]

K.	Prostate	Gland in the male which contributes to the seminal fluid and accounts for the liquefaction of the coagulated semen. Fluid contains acid phosphatase, citric acid and proteolytic enzymes.[1]
L.	Scrotum	The pouch which contains the testicles and their accessory organs.[1,9]
M.	Testes	Male sex organs (gonads) which produce spermatozoa and testosterone.[1]
N.	Urethra	The membranous canal which conveys urine from the bladder to the exterior of the body.[1]
1.	Urethral meatus (orifice)	The external opening of the canal leading from the bladder.[1]
2.	Urethritis	Inflammation of the urethra.[1] Usually a non-specific finding, however, may be caused by a sexually transmitted disease.
O.	Vas Deferens	The excretory duct of the testicle, passing from the testis to the ejaculatory duct.[1]

4. Anal

A.	Anal Dilation (dilatation)	Opening of the anus secondary to relaxation of the external (and possibly the internal) anal sphincter muscles with minimal traction on the buttocks.[9] A finding that must be interpreted with caution. Anal dilatation has been observed in both abused and non-abused children. It is associated with a variety of causes including sedation, anesthesia and trauma. It is a common post mortem finding.[23,28,82,87,106 ,109,110,111,112] Anal dilation that occurs within 30 seconds, is greater than 20mm in the A-P diameter with no stool present in the rectal ampulla has been associated with prior anal trauma.[23,28,39,42,62,77,106,107,112]
B.	Anal Fissure	A superficial break (split) in the perianal skin which radiates out from the anal orifice.[9] A variety of causes including the passage of hard stools (constipation), diseases such as Crohn's Disease and trauma.[37, 39,68,106,109,111,112]
C.	Anal Laxity	Decrease in muscle tone of the anal sphincters resulting in dilation of the anus.[23,28,106,109,117] May occur immediately following an acute/forced sodomy.[28,42,106,109,111]

D.	Anal Skin Tag	A protrusion of anal verge tissue which interrupts the symmetry of the perianal skin folds.[9] A projection of tissue on the perianal skin. When located outside the midline, causes other than a congenital variation should be considered, including such things as Crohn's disease or trauma.[42,77,82,106,107,109,115,120,121]
E.	Anal Spasm	An involuntary contraction of the anal sphincter muscles. May be attended by pain and interference with function.[1] May be found immediately post assault.[42,62,107]
F.	Anal Verge	The tissue overlying the subcutaneous external anal sphincter at the most distal portion of the anal canal (anoderm) and extends exteriorly to the margin of the anal skin.[9,94,121]
G.	"Anal Wink"	Reflex anal sphincter muscle contraction as a result of stroking the perianal skin. Used to determine sensory nerve function.[37,111,112] Relationship to sexual abuse is unknown.
H.	Anus	The anal orifice, which is the lower opening of the digestive tract, lying in the fold between the buttocks.[1,9]
I.	Diastasis Ani (Smooth Area)	A smooth, often "V" or wedge shaped area at either the 6 or 12 o'clock positions in the perianal region. It is due to the absence of the underlying corrugator external anal sphincter muscle and results in a loss of the usual anal skin folds in the area.[4,9,23,41] A congenital variant.[23,39]
J.	Ecchymosis of the Perianal Tissues	A hemorrhagic area (bruise) on the skin or mucous membrane of the perianal tissues due to extravasation of blood most commonly caused by external trauma.[1] May be confused with venous congestion and postmortem lividity.[23,118]
K.	Edema (Swelling)	The presence of abnormal amounts of fluid in the intercellular space.[1] If secondary to trauma, it will usually be accompanied by erythema, pain and swelling of perianal skin folds.[1,28,109]

L.	Erythema (Perianal)	Perianal erythema: A redness of the skin or mucous membranes due to congestion of the capillaries.[1] A non-specific finding that may result from a variety of causes including, improper hygiene, infection or trauma.[23,106,109]
M.	Fistula in Ano	Perianal fistulas resulting from developmental abnormalities of the mucosal glands at the base of the anal crypts. Usually manifests as a draining pustule in the first year of life. More common in males (4:1)[121]
N.	Flattened Anal Skin Folds	A reduction or absence of the perianal folds or wrinkles, noted when the external anal sphincter is partially or completely relaxed.[9] The relationship to sexual abuse is unknown. A common finding in sedated, relaxed children and at autopsy.[23,82,112]
O.	Funnel Appearance	A decrease in the fatty (subcutaneous) tissue surrounding the anus, leading to a concave appearance.[111,112] Relationship to sexual abuse is unknown.
P.	Hemorrhoid	A varicose dilatation of a vein of the superior or inferior hemorrhoidal plexus, resulting from a persistent increase in venous pressure.[1]
Q.	Hyperpigmentation	Increase in melanin pigment within the perianal tissues.[1] A common congenital finding in darker skinned children. May be associated with post-inflammatory changes.[23,106]
R.	Intermittent anal dilation	Anus dilates intermittently during examination, particularly in the prone knee-chest position. A common finding in children of all ages.[23,112]
S.	Lacerations (Perianal)	A tear in the tissues immediately surrounding the anus. May result from a variety of causes including the passage of hard stools and the insertion of foreign objects, including a penis.[68,82,106,109,112,115] Failure of fusion of the median raphe may simulate a laceration.[120]

T.	Pectinate Line (Dentate line)	The saw-toothed line of demarcation between the distal (lower) portion of the anal valves and the pecten, a smooth zone of simple stratified epithelium which extends to the anal verge.[1] The pectinate line only appears when the external and internal anal sphincters relax and the anus dilates. A common finding at autopsy.[9,113]
U.	Perianal Skin Folds	Wrinkles or folds of perianal skin radiating from the anus, which are created by the contraction of the external anal sphincter.[9]
V.	Perianal Venous Congestion	The collection of venous blood in the venous plexus of the peri-anal tissues creating a flat, purple discoloration. May be localized or diffuse.[23] A common finding in children when the thighs are flexed upon the hips for an extended period of time.[23]
W.	Perianal Venous Engorgement (Pooling)	Pooling of venous blood in the perianal tissues creating a bluish-purple bulging of the tissues. May be localized or diffuse. Significance is currently unknown.
X.	Rectum	The distal portion of the large intestine, beginning anterior to the third sacral vertebra as a continuation of the sigmoid and ending at the anal canal.[1] Terminal (lower) end of the intestinal tract (colon).[1]
Y.	Reflex Anal Dilatation	Anal dilation which occurs upon stroking the buttocks.[111,114] Once considered to be evidence of prior sexual abuse. Relationship to sexual abuse is currently unclear.[28,39,111,112] Refer to anal dilation and anal wink.
Z.	Scars of Perianal Tissues	Scar formation in the tissues immediately surrounding the anus. While scar formation is usually a result of prior trauma it is an uncommon finding. Injured perianal tissues heal rapidly and leave little evidence of prior trauma.[82.109] Diastasis ani, a congenital variation, may be confused with scar formation.[39]

AA. Shallow Anal Canal

Relaxation of the anal sphincter muscles causing a flattening of the anal verge that may lead to exposure of the pectinate line and the anal canal.

A common finding during anesthesia, following sedation and at autopsy.[79,82,113]

Relationship to sexual abuse is unknown.

BB. Tag (Anal)

A protrusion of anal verge tissue which interrupts the symmetry of the perianal skin folds.[9]

Perianal skin tags outside the midline may be evidence of prior trauma.[41,82,106,107,109,121]

5. Infections of the Uro-genital Tract

A. Bacterial Vaginosis

Altered vaginal flora resulting in a malodorous discharge. Gardnerella vaginalis, Bacteroides, Mobiluncus and Peptococcus species have been found in increased numbers in this condition. Characterized by 1) Increase in the pH; 2) Malodorous discharge; 3) Abnormal flora; 4) Positive "whiff test" (i.e. the release of a “fishy”, amine odor upon the addition of KOH to a drop of vaginal fluid) and; 5) Clue cells.

A common finding in sexually active adults and adolescents. Relationship to sexual abuse in prepubertal females is unclear.[5,6,7,8,123,124,125]

B. Candidiasis

Yeast (moniliasis) infection caused by Candida species.[1]

A common cause of "diaper dermatitis" in infants. An uncommon vaginal infection in prepubertal children.[5,121]

A common vaginal infection in adolescents and adult females.[5,121]

C. Chlamydia Trachomatis

A sexually transmitted organism. May be transmitted to newborns during the birth process and carried in an asymptomatic state.[37,121,124,126,-134]

D. Condylomata Acuminata

Venereal warts caused by human papilloma virus. A sexually transmitted disease in adults. May be transmitted to newborns during the birth process.[135-141]

Children with condyloma acuminata should be evaluated for the possibility of sexual abuse.[135,137,142]

E.	Gardnerella Vaginalis	A bacterium commonly found in sexually active females and associated with bacterial vaginosis.[94,123]
F.	Genital Mycoplasma	A common organism found in sexually active females.[5,6,7,8]
G.	Gonorrhea	Infection due to a gram negative, intracellular diplococcus *Neisseria gonorrhoeae*.[1] A sexually transmitted disease in most cases. May be transmitted to newborns during the birth process.[94,121,143-146]
H.	Hepatitis B	A viral infection with multiple modes of transmission. It may be acquired during the birth process, at the time of sexual contact and from blood products. It is endemic in certain populations such as Southeast Asians.[121]
I.	Herpes Simplex Virus-1	A viral infection that may be sexually transmitted.[94,121,147,148]
J.	Herpes Simplex Virus-2	A viral infection that is usually sexually transmitted.[94,121,147,148]
L.	Human Immune Deficiency Virus (HIV)	A sexually transmitted viral infection. May be transmitted at birth, through breast milk, blood products, semen, vaginal secretions and possibly other body fluids.[94,121,149-152]
L.	Lactobacillus	Anaerobic or microaerophilic organisms that occur widely in nature, including the mouth, vagina and intestinal tract.[121] Normal flora in the vagina of post-pubertal females.[121]
M.	Molluscum contagiosum	A common, benign, usually self-limited viral infection of the skin and conjunctiva by a poxvirus. Transmitted by autoinoculation, close contact. Primarily affects children but may also be seen in adolescents and adults in whom it may be sexually transmitted.[1,121]
N.	Moniliasis	Yeast (moniliasis) infection caused by Candida species.[1] A common cause of "diaper dermatitis" in infants. An uncommon vaginal infection in prepubertal children.[5,121]

O.	Syphilis	Infection caused by the spirochete Treponema pallidum.[1] A sexually transmitted disease in most cases. May be transmitted to the fetus prior to or at the time of birth.[121,153-156]
P.	Trichomonas Vaginalis	Single celled protozoan which is usually sexually transmitted.[121] A cause of purulent vaginitis and may be associated with the presence of petechiae on the wall of the vagina and/or cervix.[121]

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PRACTICE
GUIDELINES

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